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Abstract

Discussed in a conference report on adolescent psychology are the varieties of behavioral problems and family dynamics by Richard Jenkins, biological growth during adolescence by J.R. Unwin, management of adolescents in a general hospital setting by Henry Kravitz, and educational problems in disturbed adolescents by S.J. Shamsie, Jean-L. Lapointe, and H. Boudin. Additional articles are concerned with adolescents in the family (Ronald B. Feldman), adolescents in Juvenile Court (S.J. Shamsie), and adolescence as rebirth (Vivian Rakoff). Also included is a panel discussion on the need for separate treatment facilities for adolescents (W.J. Hendrickson, H. Caplan, G.J. Sarwer-Foner, H.E. Lehmann, and S.J. Shamsie). (JM)

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Adolescent Psychiatry

Proceedings of a Conference
Held at Douglas Hospital
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Edited by S. J. Shamsie, MD

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Preface

There has been a reluctance in using the term "Adolescent Psychiatry." The reluctance is indicative of the fear of splitting the field of psychiatry into too many sub-specialities. Traditionally, treatment of adolescents has been in the province of child psychiatry. On the other hand, a large number of psychiatrists are treating adolescents who have had no formal training in child psychiatry.

Child psychiatrists have considered adolescents as older children and psychiatrists dealing with adults have looked upon the adolescents as younger adults. Both have felt that their training entitles them to treat this age group. Though both child and general psychiatrists have made claim to be qualified to treat adolescent both are reluctant to accept the child in this age group. A fifteen year old is usually referred from child psychiatrists to general psychiatrists and if he happens to be a difficult case, no one wants to accept the responsibility of treating this individual. With young people forming a greater part of the population each year the need for providing adequate in-patient and out-patient services for the adolescent has become more acute in recent years.

The experience and the training with children is necessarily an asset to the understanding of an adolescent. However, it is easy to recognize that the problems created by a six year old are very different in nature than a fifteen year old. When a six year old threatens his parents to leave the home, he neither means it nor it is feasible in reality. But this is not the case with a seventeen year old. Very often one finds that the parents who have been able to control a disturbed child, though with difficulty, are completely helpless when the same child grows up into an adolescent.

The advent of puberty brings with it new problems to be faced both by the adolescent and his family. The sudden biological growth to which Dr. Unwin's paper is devoted, the appearance of sex, the problem of identity and the conflict of dependency and independence, all make this period of life markedly different from either childhood or adulthood. The modes of expression of the emotional problems are also somewhat unique. Frequent suicidal attempts, running away from home, promiscuity and a defiant and negative attitude towards the parents are some of the ways of expressing these conflicts. With boys, there is a tendency of expressing hostility and anger more directly, stealing of cars, destruction of property and defiance of the law are the ways most commonly chosen by these youngsters. The recent increase in the incidence of taking of drugs by the young is yet another expression of the emotional turmoil which is so characteristic of this age period.

Then there is the question of separate treatment facilities for adolescents. There is a panel discussion on this subject included in this book. Various viewpoints on the subject are expressed and the reader has the opportunity to look at this question from different perspectives. The answer to the question of separate treatment facilities in my opinion cannot be answered by a "yes" or "no." All adolescents need not be treated in adolescent units. Children and adult wards could provide a suitable setting for a large number of adolescents, provided there are adequate facilities for schooling and recreation. However, the staff who are taking care of these adolescents must have the necessary experience and training. This experience and training could be achieved by working in adolescent units with staff who have had the experience and are committed to the treatment of adolescents. The American Psychiatric Association in its position statement on psychiatry of adolescence has emphasized this need for training and experience for both child and general psychiatrists who intend to work with adolescents. This is also one area where there was agreement among the participants of the panel discussion.

There is no suggestion that adolescent psychiatry should be made into a sub-speciality. It is not suggested that every teen-ager who requires psychiatric treatment should be necessarily treated in a separate facility. The emphasis is on the need to get necessary experience and training for those staff who intend to work with this age group. This experience and training cannot be gained by working with children or adults.

S. J. Shamsie, MD
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January 1967

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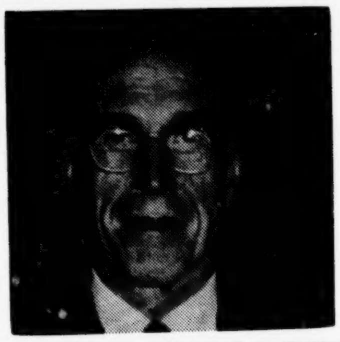

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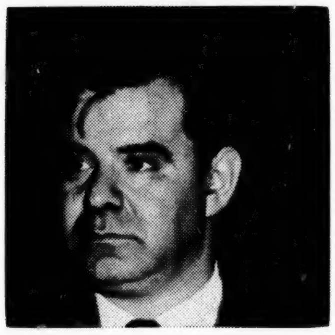

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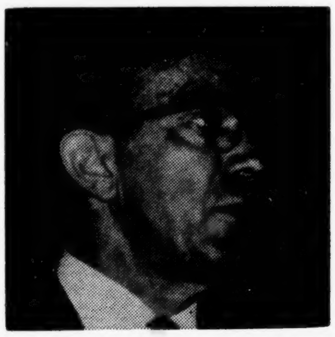

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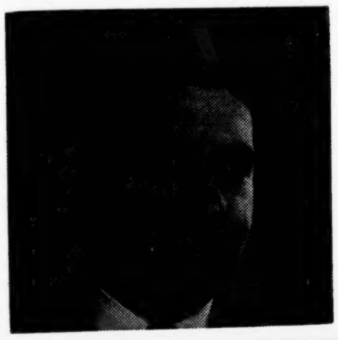

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The Varieties of Adolescent's Behavioral Problems and Family Dynamics

Richard L. Jenkins, MD

A separation of three major symptomatic groupings of children referred to a child guidance clinic was presented by Lester Hewett and myself in 1944.(1,2) At that time we recognized three large behavioral syndromes, which we called the overinhibited child, the unsocialized aggressive child, and the socialized delinquent. We recognized a characteristic family background for each syndrome–family repression for the overinhibited child, parental rejection and particularly maternal rejection for the unsocialized aggressive child, and parental negligence and exposure to delinquent behavior for the socialized delinquents.

A paper presented at a research conference in child psychiatry in 1965 and published in APA Psychiatric Research Report 18 contrasted the family backgrounds of the overanxious (or overinhibited) children, the undomesticated (or unsocialized agressive) children and the socialized delinquents as these have been revealed in a number of studies[3].

In a study published in May of 1966, a computer clustering of 500 cases of children examined in a child guidance clinic and grouped on the basis of 94 symptoms fell into five more-or-less separable clusters. These included the three groups already mentioned, and also a shy-seclusive and relatively withdrawn group, and a hyperactive-distractible group. These five groups were found to come from characteristically different family backgrounds[4].

A further study based on the cases of 300 children examined in the Child Psychiatry Service at the University of Iowa contrasted parental responses to an intake questionnaire of six groups of children: an overanxious group, an undomesticated group, a socialized delinquent group, a withdrawn group, a brain-damaged group and a mentally retarded group. There is some correspondence between the shy-seclusive group of the last study cited and the withdrawn group described here, and substantial overlap between the symptomatic group described as hyperactive-distractible and the etiological group described as brain-damaged. The retarded group is definable only in terms of developmental retardation, not in terms of characteristic behavior.[5]

The present study is an effort to test, verify and expand the description on a larger number of cases. The study is based upon data cards for 1500 cases of children examined at the Institute for Juvenile Research, Chicago, Illinois. IBM cards on these cases, with the results of examinations coded on them, were loaned to us through the courtesy of the Institute. These cards were subjected to a computerized clustering procedure on the basis of the symptoms, signs and dynamic factors recorded from the examination. Five clinical clusters were determined. These clinical clusters are the overanxious-neurotic children, the undomesticated or unsocialized aggressive children, the socialized delinquents, the brain-damaged children and the shy, seclusive, withdrawn, schizoid children. The first three clusters will be discussed here.

The procedure differed from the study reported in 1966 in requiring less exacting criteria for inclusion in a group, and in having substantially larger numbers of cases available for comparison.

Children whose records showed at least two of the entries listed in Table 1 were classified as overanxious children. There were 287 such cases.

Children whose records showed at least two of the entries listed in Table 2 were classified as unsocialized aggressive children. There were 445 such cases.

Children with records showing one of the first four entries in Table 3 and a total of at least two of the entries in this table were classified as socialized delinquents. There were 231 such cases.

The selection of these groups is approximate. However, the number of cases is large enough so that the approximation will only dilute the size of the Phi value in such significant differences as we find.

Table 4 indicates that only about a third of our overanxious children and of our unsocialized aggressive children were over ten years of age, while about four-sevenths of our socialized delinquent group were over ten years of age. Thus, our socialized delinquent group is definitely older than our other two groups.

In Table 5, the children falling in each group are compared with all children in our study *not* falling in that group. The Phi value is a correlation coefficient, and the P value indicates the probability that this degree of relationship would occur purely on a chance basis. Thus, all the comparisons to be reported are between different symptomatic groups of child guidance clinic cases. Table 5 reveals that the socialized delinquent children tend to come from sibships of four or five children, not from the one or two child families. The tendency toward the larger sibship is also apparent, although less striking, with the unsocialized aggressive children. The position of youngest child is related to the overanxious child, negatively related to the other two syndromes.

Table 6 indicates that both the unsocialized aggressive children and the socialized delinquents come selectively from broken homes. Both are likely to have the mother as the only natural parent in the home, and to have a step-father. Only the unsocialized aggressive children are likely to live with a stepmother.

Table 7 reveals that the mothers of overanxious children are more likely than the mother of other clinic children to be characterized by the social worker as having an *infantilizing, overprotective* attitude toward the child–a description quite unlikely to be used for the mothers of the other two groups. Both of the aggressive groups are likely to have mothers whose attitude toward the child is described as *overt rejection* of the child, *punitive* toward the child, or as *acting out through the child.* A *critical, depreciative* attitude toward the child and a *lack of consistency* are characteristic of the mothers of unsocialized aggressive children. The attitude of the mother of the socialized delinquents toward the child is likely to be characterized as *cold, distant and neglectful,* and it is recorded that she is prone to *delegate parental responsibility*. Her area of difficulty is likely to be *delinquency or promiscuity,* and she was likely not to be married to the father at the time the child was conceived.

Table 8 indicates that, from the social history, the father's attitude toward the unsocialized aggressive child is likely to be characterized by *lack of consistency.* The attitudes of the fathers of the socialized delinquents are characterized as *controlling, rigid,* as *acting out through the child,* as *punitive,* and as *cold, distant, neglectful.* In the case of the overanxious child, the father's area of difficulty is likely to be recorded as *mental health,* while in the case of the socialized delinquent it is likely to be *alcoholism.*

Table 9 indicates that, according to the social history, *withdrawal of privileges* and *physical punishment* tend to be less used with the overanxious child than with the average clinic child. The parents of the unsocialized aggressive children extensively report *physical punishment* as a means of discipline; also, *withdrawal of privileges, physical restraint or confinement, physical or emotional isolation,* and that most inconsistent of methods of control, *bribery.* The parents of the socialized delinquents also report substantial use of *withdrawal of privileges,* less characteristically,*physical punishment* and *physical restraint or confinement.* Reports of *physical or emotional isolation* and of *bribery* as means of control are not associated with this kind of problem behavior. The parents of socialized delinquents do report the use of *extra chores* as a means of discipline.

Table 10 reveals that the overanxious child's relationship with his environment is characterized as *withdrawn and passive,* while it is *acting out* for the socialized delinquent, and even more characteristic of the unsocialized aggressive. The manifestation of hostility is *minimal, repressed* for the overanxious child, and *excessive, easily elicited* for the socialized delinquent, and particularly for the unsocialized aggressive child.

Table 11 reveals that the relationship of the overanxious child with the examiner is *shy, withdrawn, inhibited* or *ill at ease, apprehensive* with the overanxious child and *provocative* with the unsocialized aggressive. The overanxious child is rated as *submissive* towards his parents, while the rating is *hostile, aggressive* for the socialized delinquent, and particularly for the unsocialized aggressive child.

In the psychiatrist's judgments we find the mother's relationship to the child checked as *infantilizing, overprotective,* as *setting an example for the child's pathology,* and as sometimes involving a *marked preference for the patient.* These are revealed in Table 12. The elements which are checked as most characteristic of the attitudes of mothers of the unsocialized aggressive children are *punitive, lack of consistency, acting out through child, overly permissive, critical, depreciative, conflicting with other authorities* (often the father), *delegates parental responsibility,* and *rivalrous.* Such expressions certainly do not describe a maternal attitude which would make it easy for a child to learn to accept limits.

The descriptive characterizations *cold, distant, neglectful,* and *overt rejection* are used both with the socialized delinquents and with the unsocialized aggressive children, slightly (but not significantly) more frequently with the former. *Acting out through child* and *punitive* are used to describe the maternal attitudes of the socialized delinquent child, as well as of the unsocialized aggressive. Relative *lack of consistency* is associated with all three groups, but most conspicuously with the unsocialized aggressive child.

Table 13 reveals that the mother's concept of her self-involvement in her child's problem is typically *ambivalent* in the case of the mothers of overanxious children, but it is not *non-accepting.* It is *non-accepting* in the case of the mothers of socialized delinquents. The mothers of the unsocialized aggressive children are frequently checked as having a *character disorder or psychoneurosis.* The attitude of the mother of the socialized delinquent toward therapy for herself is typically characterized as *reluctant, resistant, refusing.*

The psychiatrist's estimate of the relationship of fathers of the overanxious children to the child as revealed in Table 14 is one of *delegating parental responsibility* – a characteristic shared by the fathers of the socialized delinquents. In the case of the unsocialized aggressive children, the father's relationship is characterized by checking such elements as *acting out through child, punitive, lack of consistency, conflicting with other authorities, overly permissive* and *rivalrous. Acting out through child* and *conflicting with other authorities* were also checked as characteristic of the father's relationship with the socialized delinquent. *Overt rejection* of the child by the father was significantly related only to the socialized delinquent.

Table 15 reveals that the fathers of the socialized delinquents are not accepting of their self-involvement in the patient's problem, nor are they accepting of therapy for themselves. The personality structure of the fathers of the overanxious children is likely to be characterized as involving a *character disturbance or psychoneurosis,* while in the case of the other two groups the problem is typically *alcoholism, delinquency*.

Both parents of socialized delinquent children show a non-acceptance of their own involvement in the patient's problem and an unwillingness to be involved in therapy.

As indicated in Table 16, *stepmothers* or *stepfathers* are often present in the family of the unsocialized aggressive children, *stepfathers* only with the socialized delinquents.

It should be clear that our overanxious children present a decided contrast with our other two groups, and that the undomesticated children and the socialized delinquents resemble each other much more than either one resembles the overanxious children. Our next step was to confine ourselves to a comparison of these two aggressive groups. When we turn to our 445 unsocialized aggressive children and our 231 socialized delinquents, we find that 129 cases fall in both groups. Eliminating these overlapping cases, we find that we have 316 cases remaining in the unsocialized aggressive group and 102 in the group of socialized delinquents. Our remaining Tables show two comparisons .First, we compare the total group of 316 unsocialized aggressive children with 102 socialized delinquents. As a second step, we match both age and sex for pairs of one unsocialized aggressive child and one socialized delinquent. This was done to eliminate the possible effect of differences between the two groups in age and sex on the comparison. This gave us 95 matched pairs, controlled on the variable of sex and reasonably well controlled on the variable of age. Our age groupings were: 5-7, (7 pairs); 8-10, (28 pairs); 11-14, (36 pairs); and over 14, (24 pairs). We have 76 pairs of boys and 19 pairs of girls.

The remaining tables list those items which reach the $P < .05$ level in either of these comparisons. In no case is the direction of the relationship reversed between the two comparisons. Since the right hand comparison is based on only 95 matched pairs, there are fewer significant relationships. A comparison of Phi values indicates whether or not, and to what extent the correlation has been reduced by matching for age and sex.

Table 17 reveals that the socialized delinquents are more likely to have 3 or 4 siblings, while the unsocialized aggressive children are more likely to be only children, and are more likely to have a stepmother.

Table 18 indicates that both parents of socialized delinquents are more likely to *delegate parental responsibility*. The mother is prone to be *cold, distant and neglectful;* the father, *controlling and rigid*. The *punitive* mother, on the other hand, is more characteristic of the unsocialized aggressive child. The Phi values of these parental attitudes are not essentially reduced by the matching process.

The relationship of each parent to the unsocialized aggressive child is characterized by *lack of consistency*. The father tends to prefer a sibling. The mother does not prefer the patient. In the 95 matched pairs, there was no instance of the mother of an unsocialized aggressive child preferring the patient, while among the socialized delinquents, there were 4 such cases.

Table 19 reveals that the mothers of the socialized delinquents are prone to *delinquency or promiscuity*, the fathers to *alcoholism*. The mothers of socialized delinquents may be characterized as *irresponsible, poor work record*. They were less likely than the parents of the unsocialized aggressive children to be married to the child's father when the child was conceived. The mothers of unsocialized aggressive children are likely to be considered as showing a *character disturbance, psychoneurosis*.

In most of the foregoing, the relationship holds up fairly well with the matched pairs. Table 20, however, would indicate that the differences between these groups of parents in their description of methods of discipline, in their acceptance of self-involvement in the patient's problem and in their attitude toward therapy for themselves become inconsequential when controlled for the sex and age of the child.

Summary

In brief, the indications in this study are that the family background of the overanxious child frequently is one with an infantilizing, overanxious mother, overconcerned about the child, often preferring it to her other children, and setting an example for the child's pathology with her own anxiety. The mother is ambivalent about her own involvement in the child's problem, but is not non-accepting of this involvement. The father delegates parental responsibility, and may have a problem of mental health, typically a character disorder or psychoneurosis.

Both parents of the unsocialized aggressive child are highly inconsistent in their relationship with the child. They are punitive, and yet they are often overly permissive. Parental immaturity is indicated by the fact that either parent may be rivalrous with the child, family instability by the frequency of a stepfather or a stepmother. The critical, depreciative and rejecting mother or stepmother is typical. The mother is likely to have a character disturbance or psychoneurosis.

The home from which the socialized delinquent comes is more likely to involve delegation of parental responsibility and a cold, distant, neglectful parental attitude. These are in part the product of the large family in meager economic circumstances. The parental pathology is more paternal than maternal and frequently includes the alcoholic father or stepfather. Neither parent is likely to be accepting of his involvement in the patient's problem nor accepting of therapy for himself.

If we contrast these two groups, we find that the unsocialized aggressive child is more likely than the socialized delinquent to be an only child, to have a stepmother or a punitive mother and much parental inconsistency. The present findings support the formulation that, as compared with the unsocialized aggressive child, the socialized delinquent is more a product of parental neglect and delegated parental responsibility. The development of the unsocialized aggressive child appears to involve a large measure of direct response to parental rejection and inconsistency, while the parental contribution to the problem of the socialized delinquent appears to be more one of a failure of parental control.

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Table 1, Selection of Overanxious Cases

Overanxious children were defined as any having at least two of the following entries:

	Total entries in 1500 cases
Generally immature	402
Chronically anxious or fearful	188
Reluctance or fear of school	167
Shy	143
Overly conforming, submissive	85
Frequent nightmares	79
Sleep disturbances other than nightmares	70
Difficulty in separating from mother	66

Cases classified as overanxious–287

Table 2, Selection of Unsocialized Aggressive Cases

Unsocialized aggressive children were defined as any having at least two of the following entries:

	Total entries in 1500 cases
Disobedience with hostile component	418
Temper	416
Bullying, domineering, aggressive	397
Lying	227
Destructiveness	159
Firesetting	70
Cases classified as unsocialized aggressive	445

Table 3, Selection of Socialized Delinquency Cases

Socialized delinquents were defined as any having at least one of the first four entries, and at least two of the total:

	Total entries in 1500 cases
Stealing	215
Truancy from School	116
Running away from Home	67
Group Stealing	45
Psychiatrist's judgment that primary problem area is socially unacceptable acts	276
Relationship made by child with psychiatrist is guarded, defensive, resistive	209
Relationship made by child with psychologist is guarded, defensive, suspicious	101
Cases classified as socialized delinquents	231

Table 4

	Overanxious	Unsocialized Aggressive	Socialized Delinquent
Number of cases	287	445	231
Per cent over 10 years of age	32	36	57
Per cent girls	35	20	22

Table 5, Identifying, Administrative and Sociological Data

	Overanxious	Unsocialized Aggressive	Socialized Delinquent
Number of Siblings:			
None			–.06 ($P < .05$)
One		–.05 ($P < .05$)	–.10 ($P < .001$)
Three or four		.06 ($P < .05$)	.15 ($P < .001$)
Youngest Child	.06 ($P < .05$)	–.07 ($P < .01$)	–.07 ($P < .01$)

Table 6, Identifying, Administrative and Sociological Data

	Overanxious	Unsocialized Aggressive	Socialized Delinquent
Both natural parents in the home		–.13 ($P < .001$)	–.14 ($P < .001$)
Mother only natural parent in the home		.10 ($P < .001$)	.12 ($P < .001$)
Father only natural parent in the home		.09 ($P < .01$)	
Parents separated or divorced		.12 ($P < .001$)	.12 ($P < .001$)
Stepparent in home		.18 ($P < .001$)	.11 ($P < .001$)

Table 7, Social History

	Overanxious	Unsocialized Aggressive	Socialized Delinquent
Mother's Attitude Toward Patient:			
Infantilizing, overprotective	.11 ($P < .001$)	–.09 ($P < .01$)	–.08 ($P < .01$)
Critical, depreciative		.09 ($P < .01$)	
Lack of consistency		.08 ($P < .01$)	
Cold, distant, neglectful			.08 ($P < .01$)
Delegates parental responsibility			.11 ($P < .001$)
Overt rejection		.12 ($P < .001$)	.12 ($P < .001$)
Punitive		.08 ($P < .01$)	.10 ($P < .001$)
Acting out through child		.07 ($P < .01$)	.07 ($P < .01$)
Mother's Area of Difficulty:			
Delinquency or promiscuity			.13 ($P < .01$)
Marital Status of Mother When Patient Was Conceived:			
Not married to father			.11 ($P < .001$)

Table 8, Social History

	Overanxious	Unsocialized Aggressive	Socialized Delinquent
Father's Attitude Toward Patient:			
Lack of consistency		.08 ($P < .01$)	
Controlling, rigid			.08 ($P < .01$)
Acting out through child			.07 ($P < .01$)
Punitive			.05 ($P < .05$)
Cold, distant, neglectful			.05 ($P < .05$)
Father's Area of Difficulty:			
Mental health	.06 ($P < .05$)		
Alcoholism			.07 ($P < .05$)

Table 9, Social History

	Overanxious	Unsocialized Aggressive	Socialized Delinquent
Types of Discipline:			
Physical punishment	–.06 ($P < .05$)	.18 ($P < .001$)	.09 ($P < .01$)
Withdrawal of privileges	–.11 ($P < .001$)	.13 ($P < .001$)	.12 ($P < .001$)
Physical restraint or confinement		.12 ($P < .001$)	.09 ($P < .01$)
Physical or emotional isolation		.09 ($P < .001$)	
Bribery		.06 ($P < .05$)	
Extra chores			.06 ($P < .05$)

Table 10, Psychological Examination

	Overanxious	Unsocialized Aggressive	Socialized Delinquent
Relationship With Environment:			
Withdrawn-passive	.09 ($P < .01$)	–.09 ($P < .01$)	–.10 ($P < .001$)
Acting out		.17 ($P < .001$)	.13 ($P < .001$)
Manifestation of Hostility:			
Excessive, easily elicited		.18 ($P < .001$)	.10 ($P < .001$)
Minimal, hostility repressed	.05 ($P < .05$)	–.10 ($P < .001$)	

Table 11, Psychological Examination

	Overanxious	Unsocialized Aggressive	Socialized Delinquent
Relationship With Examiner:			
Shy, withdrawn, inhibited	.07 ($P < .01$)	–.07 ($P < .01$)	
Ill at ease, apprehensive	.07 ($P < .05$)		
Provocative		.08 ($P < .01$)	
Relationship With Parents:			
Submissive	.07 ($P < .01$)	–.09 ($P < .01$)	–.06 ($P < .05$)
Hostile, aggressive	–.06 ($P < .05$)	.11 ($P < .001$)	.07 ($P < .01$)

Table 12, Psychiatric Examination

	Overanxious	Unsocialized Aggressive	Socialized Delinquent
Mother's Relationship To Child:			
Infantilizing, overprotective	.19 ($P < .001$)	–.06 ($P < .05$)	–.09 ($P < .01$)
Setting example for child's pathology	.12 ($P < .001$)		
Marked preference for patient	.07 ($P < .01$)		
Punitive		.17 ($P < .001$)	.08 ($P < .01$)
Lack of consistency	.07 ($P < .01$)	.17 ($P < .001$)	.05 ($P < .05$)
Acting out through child		.15 ($P < .001$)	.09 ($P < .01$)
Overly permissive		.10 ($P < .001$)	
Critical, depreciative		.09 ($P < .01$)	
Conflicting with other authorities		.08 ($P < .01$)	
Delegates parental responsibility		.06 ($P < .05$)	
Rivalrous		.05 ($P < .05$)	
Cold, distant, neglectful		.09 ($P < .01$)	.12 ($P < .001$)
Overt rejection		.09 ($P < .01$)	.10 ($P < .01$)

Table 13, Psychiatric Examination

	Overanxious	Unsocialized Aggressive	Socialized Delinquent
Mother's Concept of Self-involvement in Patient's Problem:			
Acceptance			–.10 ($P < .001$)
Ambivalent	.08 ($P < .01$)		
Non-accepting	–.05 ($P < .05$)		.08 ($P < .01$)
Personality Structure of Mother			
Character disorder, psychoneurosis		.08 ($P < .01$)	
Mother's Attitude Toward Therapy for Herself			
Eager or accepting			–.06 ($P < .05$)
Reluctant, resistant, refusing			.10 ($P < .001$)

Table 14, Psychiatric Examination

	Overanxious	Unsocialized Aggressive	Socialized Delinquent
Father's Relationship With Child:			
Delegates parental responsibility	.07 ($P < .05$)		.05 ($P < .05$)
Acting out through child		.15 ($P < .001$)	.10 ($P < .001$)
Punitive		.13 ($P < .001$)	
Lack of consistency		.10 ($P < .001$)	
Conflicting with other authorities		.09 ($P < .01$)	.05 ($P < .05$)
Overly permissive		.08 ($P < .01$)	
Rivalrous		.08 ($P < .01$)	
Overt rejection			.06 ($P < .05$)

Table 15, Psychiatric Examination

	Overanxious	Unsocialized Aggressive	Socialized Delinquent
Father's Concept of Self-Involvement in Patient's Problem:			
Acceptance			−.10 ($P < .001$)
Personality Structure of Father:			
Character disturbance, psychoneurosis	.05 ($P < .05$)		
Alcoholism, delinquency		.06 ($P < .05$)	.05 ($P < .05$)
Father's Attitude Toward Therapy for Himself:			
Eager or accepting			−.05 ($P < .05$)

Table 16, Psychiatric Examination

	Overanxious	Unsocialized Aggressive	Socialized Delinquent
Parents Other Than Natural Parents:			
Stepmother		.13 ($P < .001$)	
Stepfather		.12 ($P < .001$)	.14 ($P < .001$)

Table 17, Unsocialized Aggressive vs. Socialized Delinquent

Identifying Administrative and Sociological Data	Overlapping Cases Excluded	Matched Pairs
Number of Siblings:		
None	–.12 ($P < .05$)	–.09*
Three or Four	.18 ($P < .01$)	.16 ($P < .05$)
Psychiatric Examination		
Parents Other Than Natural Parents:		
Stepmother	–.10* ($P < .05$)	–*No stepmothers in socialized delinquent group. 9 in unsocialized aggressive ($P < .004$)
	*Expectancy of Less than 5 in one cell	

Table 18, Unsocialized Aggressive vs. Socialized Delinquent

Social History	Overlapping Cases Excluded	Matched Pairs
Mother's Attitudes Toward Patient:		
Delegates parental responsibility	.14 ($P < .01$)	.11
Cold, distant, neglectful	.10 ($P < .05$)	.11
Punitive	–.13 ($P < .1$)	–.13 ($P < .05$)
Father's Attitude Toward Patient:		
Delegates parental responsibility	.15 ($P < .01$)	.14 ($P < .1$)
Controlling, rigid	.11 ($P < .05$)	.11
Psychiatric Examination		
Mother's Relationship With Child:		
Lack of consistency	–.12 ($P < .05$)	–.12 ($P < .1$)
Marked preference for patient	.10 ($P < .05$)	+ *(All 4 cases fall in one category, $P < .13$)
Father's Relationship With Child:		
Lack of consistency	–.10 ($P < .05$)	–.09
Marked preference for sibling	–.10 ($P < .05$)	–.12* ($P < .1$)
	*Expectancy of Less than 5 in one cell	

Table 19, Unsocialized Aggressive vs. Socialized Delinquent

	Overlapping Cases Excluded	Matched Pairs
Social History		
Mother's Area of Difficulty: Delinquency or promiscuity	.13* ($P < .01$)	.11*
Marital Status of Mother When Patient Was Conceived: Not Married to Father	.15 ($P < .01$)	.12 ($P < .1$)
Father's Area of Difficulty: Alcoholism	.13 ($P < .01$)	.08
Psychiatric Examination		
Personality Structure of Mother:		
Character disturbance, psychoneurosis	–.11 ($P < .05$)	–.11
Irresponsible, poor work record	.11* ($P < .05$)	.08*

*Expectancy of Less than 5 in one cell

Table 20, Unsocialized Aggressive vs. Socialized Delinquent

	Overlapping Cases Excluded	Matched Pairs
Social History		
Type of Discipline:		
Physical or emotional isolation	–.12 ($P < .05$)	–.04
Extra chores	.14* ($P < .01$)	+ *(All 6 cases of extra chores fall in one category $P < .03$)
Psychiatric Examination		
Mother's Concept of Self-Involvement in Patient's Problem:		
Acceptance	–.14 ($P < .01$)	–.01
Non-acceptance	.14 ($P < .01$)	.04
Father's Concept of Self-Involvement in Patient's Problem:		
Acceptance	–.16 ($P < .01$)	–.16* ($P < .05$)
Mother's Attitude Toward Therapy for Self:		
Eager or accepting	–.10 ($P < .05$)	–.06
Father's Attitude Toward Therapy for Self:		
Ambivalent	–.14 ($P < .01$)	–.03
	*Expectancy of Less than 5 in one cell	

Biological Growth During Adolescence

J. Robertson Unwin, MD

As specialists in the field we are all aware that adolescence is a critical period of development and that development during the teenage years is progressing disharmoniously in the somatic, psychological, intellectual and sociocultural spheres. Despite the acceptance of this viewpoint of the youthful organism as a maturing biopsychosocial entity, it is surprising how apparently little weight the psychiatrist usually gives to biological factors in his assessment of the individual case. Yet we know that the rate of growth during the adolescent growth spurt is equal to that during the second year of life; that entirely new physical abilities and sensations burst into awareness at a rate and with an impact frequently alarming to the youth; and that there is wide variation in the normal age of onset, velocity of development, and age of completion of the growth processes in the various somatic systems–osseous, sexual, muscular, etc.

Fritz Redl, in his address to the 6th International Congress of Child Psychiatry[24] warned of the need for a global approach to any consideration of adolescent development, and Duche, Schonfeld and Tomkiewicz, in the special pre-Congress publication[4] stated: "The understanding of adolescent personality development and the significance of specific behavior would be enhanced if the mental health specialists were to correlate their findings not only with the chronological age but also with the level of (biological) development." These authors further comment that an accurate assessment of the stage of biological maturation for a particular adolescent is "surprisingly easy, useful, but rarely done." Adequate techniques and data with which to evaluate the physical maturity of adolescents are available to us, headed by the classic studies by Tanner[21] in England, by the work of the Gallaghers, Schonfeld, and Reynolds and Wines[5,15,19,13,14] in the United States, and by the transcultural studies of Bouterline-Young[2]. Nor need the evaluation of maturity involve expensive equipment, X-rays or biochemical assays–Tanner[21] has devised a reliable pubertal maturity index derived from observation of the primary and secondary sexual characteristics, height, weight and so on; and several authors[9,17] have described simple clinical stratagems for assessing biological maturity while conducting the physical and psychiatric examinations.

The sequence of normal development in adolescence

We should at this point review in outline the main features of the biological growth processes in adolescence, confining our attention to those features which are readily observable while not forgetting that these growth phenomena are dependent on, reflected in, and closely monitored by current endocrinological and other biochemical processes[7]. Though the *sequence* to be described is invariable for each adolescent, I must stress that the normal age of onset and the normal rate of progression varies within wide limits, and this variation *must* be taken into account in any attempt to evaluate the stage of maturity of any individual case. We are talking here of statistical averages, not of ideal norms.

There is an abrupt spurt in growth which begins in early adolescence, the rate increasing progressively and reaching the point of maximum increment in mid-adolescence, about the time that pubic hair is first appearing[4]. The secondary sex characteristics develop concurrently with the height spurt. Because adolescence tends to commence two years earlier in girls, the girls catch up with and pass the height of boys of the same age during early adolescence, so that from the ages of 11 to 13 girls are usually heavier and taller than boys; the boys, however, soon commence a phase of more rapid development, usually pass the girls, and this difference in size continues to increase up to full maturity, as both the intensity and duration of the growth spurt are greater in boys. As muscles grow the strength virtually doubles in the couple of years between early and mid-adolescence, much more so in boys than in girls. At the same time there is an increase in the number of red cells in the blood to provide more oxygen to muscles and to allow for an increase in strength–once more, more markedly in boys than in girls. The actual timing of onset of the period of accelerated growth accounts for the variation in the size of different adolescents of the same chronological age[4].

During childhood and pre-adolescence there is no pubic or axillary hair, the rate of growth has been constant with no spurt (other than a slight mid-childhood peak), the penis and testes have not grown appreciably since infancy, and the breasts have been flat.

Girls

Early-adolescence (extending between the ages of 10 and 11 years, with a range from 9 to 14 years of age): The first easily-observable changes are in the hips and breasts. The hips become rounded, due partly to broadening of the bony pelvis but even more to the deposition of subcutaneous fat. Elevation of the areola of the nipple results in a conical elevation of the center of the breast called the "bud stage." There is as yet no true pubic or axillary hair, though there may be a downy growth at the pubis.

Mid-adolescence (extending between 11 and 14 years of age, with a range from 10 to 16 years): Pigmented pubic hair appears, at first coarse and straight and confined primarily to the area along the labia. Later in mid-adolescence the pubic hair becomes curled and spreads over the mons, becomes profuse and forms the classical female pattern of an inverse triangle. Axillary hair also appears during this phase, about two years after the first appearance of pubic hair. The marked spurt in height increase is most pronounced during mid-adolescence, about 1½ years before the onset of menstruation. Deposition of fat under the areola results in further elevation of the nipple and areola and the formation of what is called the "primary breast." It is during mid-adolescence that, as a result of hypertrophy of the uterus and cyclic changes in the endometrium, menstruation begins–at an average age for North America of 12.9 years +/— 1.4 years. The labia majora, virtually nonexistent in childhood, begin to enlarge. Note that the onset of menstruation follows the beginning of development of the breasts and the appearance of pubic hair. Initially the girl is sterile, as the menstrual cycle is not accompanied by ovulation; the ability to conceive is achieved one to three years after the beginning of menstruation, which occurs during mid-adolescence.

Late-adolescence (extending between 14 and 16 years of age, with a range from 13 to 18 years of age): Now the pubic hair becomes fully developed, spreading to the medial surface of the thigh. There is enlargement of the breast tissue itself and further deposition of fat, to form the contours of the mature female breast. Menstruation becomes well-established and the rate of growth decelerates, ceasing at about 16 years 3 months +/— 13 months[4].

Boys

Early-adolescence (extending between the ages of 12 and 13 years, with a range from 10 to 15 years of age): In this phase the testes begin to increase in size, the scrotum grows and its skin reddens and becomes coarser. The penis increases in length and circumference. There is no true pubic or axillary hair, though there may be a downy growth over the pubis. Note that genital maturation usually begins before the appearance pubic hair.

Mid-adolescence (extending between the ages of 13 and 16 years, with a range from 11 to 18 years of age): This next phase begins during the year following the first signs of sexual maturation. The testes continue to grow and the skin of the scrotum becomes pigmented and sculptured. The pubic hair, at first downy, becomes pigmented, sparse and straight (or slightly curled at the base of the penis). Over the next two to three years it becomes more curled and profuse, and subsequently spreads up to the umbilicus in the characteristic male pattern, thus marking the end of mid-adolescence. The penis continues its growth in length and circumference, becoming now erect not only in response to local stimuli as in childhood but also as a result of sexually-exciting thoughts. The first seminal emission occurs about 12 months following the onset of accelerated penile growth; only one to three years later however do enough motile spermatozoa appear in the ejaculate to render the boy fertile. Axillary hair appears about two years after the appearance of pubic hair and is accompanied by the appearance of hair on the upper lip. During this phase of mid-adolescence the male nipple becomes pigmented, and the voice begins to deepen as a result of growth of the larynx. We have in this phase the pronounced increase in the velocity of growth in height and weight which is so characteristic of the adolescent boy; the maximum rate is found at the time the pubic hair first develops, and deceleration occurs by the time the pubic hair has reached its adult configuration and extent. The muscles have their maximum rate of development about three months after the peak height velocity; the maximum weight gain occurs six months after the height peak. The peak in strength is 12 to 14 months after the height peak and 9 to 12 months after the weight peak[21].

Late-adolescence (extending between the ages of 16 and 18 years, with a range from 14 to 20 years of age): During this phase facial and body hair appears (though there are prominent differences among the various ethnic groups). Pubic and axillary hair becomes denser and the penis continues to grow (though there is, during the adult stage of genital maturation, a tendency for an actual reduction in the size of the penis from the maximum dimensions attained during adolescence)[14]. Ejaculations now contain enough motile spermatozoa for fertility. The rate of growth in height gradually decelerates with 98% of the mature stature attained by the age of 17 years 9 months +/— 10 months. With bitemporal indentation of the hair line on the forehead adolescence can, from a biological point of view, be said to be completed[14,21].

Though it is strictly beyond the scope of this paper, it might be appropriate to recall here that maturation of the intellectual processes during adolescence results in the attainment of the level of propositional operations, as detailed by Inhelder and Piaget.

The significance of the valid assessment of maturity

At the above-mentioned Edinburgh conference on Puberty and Adolescence[24] Tanner judged that, from a developmental status viewpoint, to speak of a 14-year old or 16-year old boy (that is, in terms of chronological age) is a "meaningless noise." The use of the chronological age is rendered unjustifiable by consideration of:

1. The wide variation in the age of onset of puberty and of the growth spurt;
2. The wide variation in the actual rate of growth during adolescence; and
3. The world-wide trend towards earlier onset of puberty and the trend for adolescents to be taller and heavier than those of preceding generations.

These points bear elaboration. For girls, adolescence usually occurs between the ages of 10 and 18 years, and for boys between the ages of 12 and 20; however, the onset may be at any age from 9 to 16 years and the end anywhere between 13 and 20[4]. So one youth may have completed his adolescent somatic maturation when another of the same chronological age is just beginning. Add to this the variation in the velocity of growth and it becomes clear that a comparison of the biological maturity of three boys of the same chronological age (say, 14 years) may reveal one to be pre-adolescent, one mid-adolescent, and one approaching full maturity. The significance of this becomes even more readily apparent when we recall the impact on the average adolescent of the invariably accelerated physical development, necessitating as it does elaboration of the evolving identity and modification of the pre-existing body-image (which for several years preceding adolescence has remained fairly stable due to the slow, smooth curve of growth up to puberty). The heightened concern with body-image and identity is augmented by the individual's reaction to late or abnormal development, by the reaction of adults (particularly parents) to the musculo-skeletal and sexual blooming during adolescence[1], and by the value judgments (in terms of virility, femininity, social prestige and athletic prowess) which the peer group and culture attach to the stage and dimensions of physical maturity.

It has been established that the early-maturer has distinct advantages over those peers of the same chronological age whose onset of puberty has been delayed (even within normal limits) or whose rate of growth is slower. The early-maturer, as compared with the late-maturer, has a higher score on intelligence tests at all ages up to 17, greater athletic prowess, is stronger, usually socially more self-confident, and is endowed by his peers with greater social prestige. Adults tend to rate the early-maturer as "more attractive" and the teacher is more likely to treat him as an equal. Early-maturers have been found to gain significantly more success than late-maturers in exams for entrance to secondary schools, and the reports of teachers upon their behavior were also more favorable[21]. Post-menarcheal girls have been found to score higher on Rorschach measures of emotional maturity than pre-menarcheal girls of the same age and educational status[21]. For a group of 17-year olds given the Thematic Apperception Test those who were late-maturers evidenced greater feelings of inadequacy and rejection[21].

This is not to imply that the early-maturer has everything in his or her favor–adults may misconstrue biological maturity as implying more emotional or social maturity than the adolescent has had time and experience to acquire, and may thus thrust him into positions of responsibility, independence and decision-making which he is not yet able to assume. It is in this context that Erik Erikson's concept of adolescence as a psychosocial moratorium–a "time-out" during which the youth organises the components of his crystallising identity–is so useful, cautioning us as it does to give the adolescent time and opportunity to test and consolidate his emerging abilities, values and interests. There are even some biological risks for the early-maturer. For example, the development of muscle strength lags about one year behind the development of body size, and undue exertion or athletic expectation can result in injury, particularly to the epiphyses of long bones. Because of differences in body (and particularly muscle) mass, the same amount of hemoglobin in the blood of two adolescents of the same chronological age but at different stages of biological maturity can mean that the bigger boy is in fact anaemic. Girls who mature earlier tend to have more menstrual difficulties (i.e. symptoms) and to have less healthy attitudes towards menstruation (Corboz, [24]).

I have mentioned that there is a proven trend for puberty to commence at a progressively earlier age. The onset of menstruation in girls in Western Europe has been earlier by four months per decade over the period 1830 to 1960, and the trend seems to be continuing[4]. In the United States the average age for menarche since 1900 has dropped by 1.2 years[11]. This earlier onset of puberty has been accompanied by an increase in the rate of growth and by an earlier onset of growth spurt, so that today's youth reach their adult height some two years younger than those of two or three generations ago. At the same time, the adolescent of today is taller and heavier than his counterpart of previous generations. The increase in height for Western Europe appears to be about 2.5 centimeters per decade[4]. In the United States the Army recruit of 1966 was 1.2 inches taller and 18 pounds heavier than the recruit of World War I, and a half an inch taller and more than seven pounds heavier than the inductee of World War II[11]. As compared with 1885, the average Yale freshman of 1957 was 3 inches taller and 20 pounds heavier. Only about 5 percent of the freshman class of 1885 stood more than 6 feet; in 1957, 29 percent of the class was over 6 feet. This trend (at least among college students) holds true for girls also–the young ladies of Vassar and Smith were about 10 pounds heavier and about 2 inches higher in the 1950's than their counterpart at the turn of the century[11] and the empirical fieldwork done by some of my students during summer vacations suggests that this increased height and weight is suitably distributed over the individual skeletal frames!

The immediate significance of the above is, of course, that we are meeting the problems of adolescence at a progressively younger age; add to this the evidence that the social demands of the peer group are being exerted earlier[4], that the period of social and financial dependence on the parents is being extended (at least for college students), and that there has been an enormous increase in the size of the teenage population, and we need not be surprised at the demands being placed on those working in adolescent psychiatry. We should now be defining our priorities for the future in terms of service, teaching and research, for these trends are continuing. Later in this conference there is to be a panel discussion on the advisability of separate units for adolescent patients; one wonders, in view of the foregoing, if public demand and our responsibility to society give us much choice.

Common complications of adolescent biological development

We should pay attention now to some of the more frequent conditions which can present problems to the adolescent during somatic maturation. I have discussed the significance of early- and late-maturation, and there is adequate discussion in the literature of the more markedly pathological conditions which are related to adolescent development or incidental to it (e.g. [3,6,16,18]). What I wish to mention briefly here are those conditions–too often regarded as trivial by physicians–which are a common hazard for the majority of adolescents. These conditions are of significance primarily because of their potential effect on the body-image–and thus on the self-concept and identity. The adolescent is, we know, exquisitely sensitive to any aspect of body structure or appearance which seems to set him apart from his peers–and the more insecure he is as a result of unsatisfactory earlier personality development, the more sensitive will he be to evanescent or minor deviations from the real or imagined norms, even to the point of displaying the syndrome of dysmorphophobia, which Professor Uschakov of the U.S.S.R. defined at the Edinburgh congress[24] as "a delusional dissatisfaction with one's own appearance and body scheme." Let me mention incidentally that research does not support the common belief that a period of muscular incoordination and consequent awkwardness is associated with the period of rapid growth in adolescence–the clumsy adolescent is likely to have been a clumsy child.

Acne is a condition which is all too often passed off by adults as being of no real significance, but I am certain each of us here has known adolescents who have reacted with deep self-consciousness, depression and even social withdrawal to protracted or severe attacks of acne. Certainly the majority of adolescents do notice and are concerned about even small areas of pustules–a concern to which the cosmetic, pharmaceutical and advertising industries have not been reluctant to cater. Explanation of the hormonal background to the skin changes responsible for acne, clear advice concerning food and body hygiene, prescription of appropriating cleansing and drying agents, and an outline of the anticipated course of the complaint can be of considerable help in reassuring the patient. The pustules will be in evidence between the ages of 13 and 18, clearing first from the face while increasing on the back, then clearing from the back by the age of 18 or 19. Severe cases should be referred to a dermatologist, and a plastic surgeon may recommend dermabrasion for post-acne scarring, though the patient should be warned of the limitations of the latter technique.

Obesity of a simple type in adolescence often gives rise to concern about endocrinological abnormalities. Particularly during prepubescence, and again just before the height spurt, a simple form of obesity may occur in which the distribution of fat is such that the body appears to attain feminine contours; and fat over the pubis may partly bury a normally-developing penis and making it appear underdeveloped or even infantile. These suggestions of feminine development will be noticed by both the adolescent and his peers, whose comments are not always tactful and who are now acutely aware of the differences between boys and girls. The result may be a disturbance of sexual identity–and prolonged investigations perhaps for non-existent endocrinological abnormalities. Research indicates that obese adolescents often eat less than their peers of lighter weight, but indulge in far less physical activity; current therapy tends to steer away from restrictive diets and to encourage more physical activity[6,20]. This is not to belittle the significance of emotional factors in the etiology of this form of obesity and the need for psychotherapy.

Gynecomastia of a simple form is present more frequently than we realize. Corboz[24] reports that over 50% of boys at the age of 15 have a palpable disc under the nipple of at least 10 mm diameter, which may be tender. This subareolar thickening resolves spontaneously within twelve to twenty-four months or less and is of no pathological significance. There is no associated increase of estrogens in the body–the phenomenon is probably due to growth hormone. No treatment other than repeated reassurance is necessary–but the reassurance does need to be repeated as this condition is regarded with considerable anxiety by many adolescents[6]. Apart from this button-like enlargement of the breast, there is another condition–pseudogynecomastia–in which there is generalised enlargement of one or both breasts so that they become prominent as a whole, in the absence of other pathology or ingestion of estrogens. When this condition is more than transitory, surgery in the form of mastectomy may be indicated.

Stria cutanea are apparently more common too than we realise–Corboz[24] reports that over 50% of boys have some scars of stria, which are most prominent between ages of 11 and 17 and are more prominent in obese youths. Apart from disfigurement, their significance, as for obesity and gynecomastia, lies in the relationship which adolescents may presume they have to femininity.

We have been concerned in the greater part of this paper with the psychosocial and psychosexual significance of biological development. It is superfluous to state that the heightened sexual and aggressive drives of adolescence are based on and fueled by the spurt in biological maturation. In closing, we should refer briefly to the effect which psychological and social factors can have on somatic growth and maturation, though this is an area about which we know very little. One of the most interesting serendipitous findings on the effect of psychological factors on growth is that reported by Widdowson[22], wherein a group of orphans failed, as a result of a harsh, castigating housemother to achieve the anticipated gain in height and weight when compared with a control group, despite supplemental diet and increased food intake. This reminds one of the frequently observed increase in the rate of growth of boarding-school pupils during long vacations at home as compared with their periods of living in school. An example of the influence on growth of the social background is the report by Meridith[10] who surveyed studies made throughout North America and found that in mid-childhood boys of the indigent class were more than 2 inches shorter and 5 pounds lighter than those of the wealthier classes. Patton[12] has made clinical studies which suggest that failure of growth may be associated with emotional deprivation, and the work of Spitz and Bowlby is now well known.

In conclusion, in suggesting that we pay more attention to biological factors in our work–be it clinical, research or teaching–let me quote from the report of the Expert Committee of the World Health Organisation on Health Problems of Adolescence[23], which, in recommending increased attention to adolescence, states ". . . . . adolescents differ physiologically and psychologically from children and adults, and these differences should be better understood, more widely taught and more consistently remembered. Only when this has been done will it be possible to take adequate account of such factors as the rapid growth of adolescents, their high degree of activity, the interrelationship of their growth and their endocrine systems, and their requirements for a healthy personality development."

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Management of Adolescents in General Hospital Setting

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In this paper I wish to put before you some thoughts on the problems associated with the treatment of adolescents. I wish to emphasize that my presentation covers our way of handling these problems at our hospital, and is not meant to convey the idea that we have found the answer, and that these techniques should be universally accepted. Some of the problems of management are perhaps specific to our setting but many I am sure have more universal applicability. These problems are based not only on those elements of conflict as expressed by the adolescents in their behaviour, but also on relationship to the adult patient population and in large measure on the way they affect staff and how the latter regard adolescents' behaviour and problems. Thus, in using the word management in the title we give due regard to the fact that management and treatment are distinct and to the degree to which the former may make the latter possible.

Briefly, our adolescent unit consists of 8-9 adolescent in-patients administratively distinct but in fact an intimate part of a physical set-up comprising 40 patients. These latter are of all adult age groups from very old people to those young adults who imperceptibly blend with the adolescent patient population. Whether such heterogenous mixture is useful or not I'll leave to the panel to discuss later in the day. I would only like to say at this point that a distinction must be made between the accommodation and facilities. I have no doubt that special facilities are necessary, and shall elaborate on this later.

The total patient population is divided into services, and each service is looked after by a team. The adolescent treatment team consists of 2 Staff Psychiatrists, 3 Residents, 3 Nurses, a Social Worker, a Psychologist and an Occupational Therapist–and a Teacher. Coupled with this, close liaison is maintained with various social agencies regarding foster home placement and mutual consultations. Age range of our adolescent population is 11 to adult, and range of disorders covers the whole spectrum of psychiatric disorders. The only admission criteria are those based on whether we feel we can be of help.

Prior to admission or as soon thereafter as possible a home visit is arranged by the social worker. Her information regarding the natural habitat of the adolescent and the family interaction provides invaluable aid for diagnosis and management. Insofar as admission to hospital of adolescent seems often indicative of family pathology, we insist that the family, whenever there is an intact family, enter into conjoint family therapy sessions. The latter may be with a social worker, or the same resident who treats the adolescent.

Although the adolescent is involved in traditional individual therapy, there is emphasis on the large and smaller group interactions in a fashion of what has euphemistically come to be called 'milieu' therapy. The setting is entirely open-door policy and we depend on our therapeutic skill, medication and administrative rules to keep our patients on the ward. Length of stay is about 3 months. As mentioned previously, certain conditions are necessary for treatment to take place. Nowhere is this more apparent than in the area of the so-called acting-out adolescent. I say so-called because we must distinguish between acting out and all those things which displease staff and are called acting out. Strictly speaking we consider acting out to be the substitute for remembering, and behaviour of a type which make therapy as we know it, difficult if not impossible.

The philosophy of handling adolescents with these problems as with children has been subject to much trial and error–an easy going permissive attitude is most often distorted by such adolescents to mean weakness and indifference. They will constantly test out, and sooner or later permissive staff will respond with a sense of impotence and helplessness, which is often reflective of an underlying staff struggle with hostility and retaliation. It is thus, our feeling that certain rules and regulations must be clearly laid down and enforced, but only such rules as can reasonably be enforced.

These basic minimal requirements have to deal with the living arrangements, getting up, meals, participation in all programs designed for therapeutic help. At the earliest occasion after admission, and based on the information available, a treatment plan is outlined and a decision is made as to whether the adolescent in question can or cannot adhere to this basic minimal requirement that is, if he is in an acute psychotic episode, severely regressed, depressed, agitated and so on–there will not be the same expectation as from those adolescents whose admission was for neurotic or character disorder reasons. When we feel ego control is possible by the individual we expect it, where we feel it is not–we furnish it. In the category of those acting out against authority on a continuous basis–we find that the only effective tool is discharge from hospital. Interestingly enough in most instances such a step has resulted in the young patient becoming a much better therapy prospect on an outpatient or private ambulant basis.

Linda was a 15 year old, who began to show behaviour problems, including not going to school, and running around with a so-called fast crowd. Interviews with the parents soon indicated a severe problem between husband and wife. Mother was chronically depressed–Father was nursing a neurotic heart condition. He alternated between seductive promises to the daughter, provoking her quasi-promiscuity, and subsequent violent, angry, beating scenes. The girl had never been involved in a clear, decisive relationship, was never sure that anyone really meant what they said. On the ward she quickly resorted to testing and acting out manoeuvers which resulted in much strife between the nursing staff and her doctor. Repeated group discussions, interpretations were to no avail. Finally, she was told that unless she learned to act according to our rules, she would be discharged. Within the hour, she tested this out, and was discharged. Incidentally such rules require that all members of the staff have the right to act on dissension. If the nurse or the resident has to report to the staff man, then hours or even days may elapse, and begins to have all the earmarks of the home situation where mother says wait until father comes home and he is put in the position of the punisher, without ever knowing what it is really for.

Linda, on being discharged, became depressed–it was arranged that she have a therapist on an out-patient basis. Only subsequent to this, has she begun to make use of her sessions in a more constructive fashion. Her comment in relationship to this was that she would have never believed that anyone really meant what they said, and why hadn't someone done this sooner.

We have had several other incidents of a similar nature which makes us feel that this is a useful procedure.

Another problem which frequently crops up–the problem of gang formation. Periodically a number of adolescents will gang together and raise hell, terrorizing staff and patients. Our impression is, that such behaviour is usually a barometer of staff neglect. Most often when this happens we have found that underlying it as a source is an overworked resident, or sometimes an anxious one, who has withdrawn, and who for either reason has avoided or neglected his adolescent patients. If they are of the behaviour problem type, they will form the proverbial gang. They will often turn on a specific nurse, find a weak spot and terrorize her into ineffectiveness. Our technique of handling such situations is to gather all the adolescents and the staff and hold a meeting where the Clinical Director as administrator, expresses the dissatisfaction with the behaviour and emphasizes that he recognizes that they have a complaint and asks them to express it, rather than act it out. Both the patient group and staff are given an opportunity to voice their dissatisfactions with each other, and legitimate complaints are dealt with. In the most recent example the resident who had in fact neglected his patients, who were the ring leaders of the gang, was removed from the adolescent service. The gang dissolved–again subsequently expressed the feeling that they had begun to feel desperate because of their frustrations, that no one would really listen to them, and were now relieved that someone had come and put a stop to it because they couldn't even though they had wanted to. Their behaviour subsequently was that of a group rather than of a gang and at least on a group level, therapy became possible and dissatisfactions and complaints were channelled into the group sessions rather than acted out in a gang terror manner.

Those examples indicate to a large extent our philosophy with this the largest group of adolescent patients. We subscribe to the belief that their acting out can be handled, if understood as a symptomatic equivalent, by specific kinds of management. Our aim is to convert the behaviour into verbal communication. In order to do this, it becomes essential that all members of the staff, not only those directly involved with the adolescents, but the whole ward staff must have a vehicle for communicating. This means regular or emergency sessions where the staff can air their differences of opinion regarding the handling of adolescents.

It is striking, the degree to which adolescents become a battleground for adults. Often the individual therapist becomes protective of his patient and takes on all comers. Member of the staff who disagrees with him becomes for him the adolescent's enemy and his. Whenever such a situation arises, it provides us with an excellent opportunity to look at the staff strife as an example of what must have gone on at home. In this way, it becomes easier for the staff to recognize that the fault, at least on a behavioural level does not lie entirely with the parents.

Psychodynamically we operate on the principle that many adolescents struggle with intense revival of the oedipal conflict. Their attempt to resolve their conflict of closeness is to convert it to hostility and aggression. It provides a vehicle for remaining in close contact but at the same time defends against libidinal ties which are seen not only in sexual but dependent terms as well. This is what has gone on at home. This is what is repeated on the ward. Recognition by our staff make it possible to find other ways to cope with this adolescent dilemma.

Although this is a simplification and does not cover all our adolescents it is a good working principle because it applies to so many. Tenderness, kindness and closeness with significant important adults who provide welfare emotions are not easily tolerated by adolescents and must be combatted.

Conversely, of course, we know of many parental situations where the youngster is used as the weapon. He plays the game very well and here too insofar as he expects this to be the case on the ward, will often initiate it. Where from our pre-admission visits we have this information we immediately advise our staff to be aware of this possibility. A case in point, a 13 year old boy admitted for behaviour problems, was used by both parents to express their hostility toward each other. Our staff was told to expect that the young man would play off the male staff against the female–within several days of admission he began to do this. The way it was handled was to refer him back constantly to his therapist. As a result he became depressed and it began to be possible to work with him.

Turning now to another group of adolescents–the acute psychotic episode. As stated previously there are no contra-indications to admission and so we get a fair number of these during the year. Here our program is based on the needs of the individual and his marked anxiety and his faulty reality testing. Our therapeutic program is designed to handle these problems. A decision is reached as to whether to use phenothiazines but in each instance a nurse is assigned to the patient as a constant companion. Her task is to function as an auxiliary ego, to help the patient test reality and interpret reality to him. A case in point–a 17 year old boy is admitted in an acute catatonic schizophrenic state. He is given a room to himself, and has a nurse in constant attendance 24 hours a day. She may feed him, dress him, help him with his toilet activity and in some instances where she is sensitive and intuitive interpret to him. It is for us often dramatic to see how the patient comes out of his state and the degree to which he attaches himself to this nurse. Gradually he will be directed to O.T. and socialization. Here again our operational concept is that at such level of regression the patient must be protected against what for him are overwhelming external stimuli. We cut out as much as possible and only gradually reintroduce this.

I have given you a few examples of management. There are obviously many others–but I would like to return to general principles. In order to treat adolescents in a general hospital setting, we felt that definite policies of management must be laid down if we are to be of any use. The policies of management are those conditions attendant upon living in a specific setting for the purpose of a specific task–namely treatment. We have separated the two only for purposes of discussion because at some point they obviously blend into each other. We are convinced that only careful planning regarding management makes treatment possible. That we are not successful in all instances needs also to be said.

It is our experience that adolescents resort to physical expression, not only because as is often said they have excess energy but because motility is much more important for them than adults. Boredom and cooped-up feelings are frequently seen. It is in this area that we feel special facilities are necessary. Ideally a gym and a workshop should form part of a treatment setting. In a general hospital this is not always possible–it is not in ours. We thus make use of community facilities for this purpose. Our teacher who was hired to do tutorial work with those adolescents missing school soon found herself much more involved in group projects–a newspaper staffed by the adolescents mainly has become a monthly feature. Outings to swimming pools, gyms, bowling alleys and now Expo are regularly arranged.

Where a youngster has a school phobia problem, somewhere along in his treatment program he is taken to and picked up by the social worker from school daily. In most of our cases we have been fortunate in a good liaison with the Protestant School Board so that discussion regarding the patient's return to school can take place and his teacher and guidance counsellor made aware of some of the problems which may arise. We are hampered by many problems but these alone are not the obstacle. The many papers and discussions on adolescent treatment attest to the complexity and difficulty of the problem. As an example the amount of time needed for staff discussion and discussion of the patient is tremendous and not always possible.

Again, 3 months or even 6 months is often not enough and our biggest frustration remains what to do when time of discharge rolls around. In many instances we have come to the conclusion that group foster home settings are useful but not always available. This is a topic in itself. But perhaps I can touch on it. Our experience on the ward seems to indicate to us, that peer group pressures are more important for the adolescent. For this reason we have felt that well run group foster homes with possibilities for group therapy and individual contact would serve an extremely useful purpose as an extension of any hospital treatment program. Our experience with this, on a limited basis, has enhanced this opinion and over the past few years we have exerted much effort in that direction. At present we are involved with such a project to the mutual benefit of both.

It is apparent to us that the adolescents we see are but a small fraction of troubled and disturbed adolescents. Our aim is to develop and provide a comprehensive community service for adolescents with in-patient treatment facilities as only one aspect of a continuum. The biggest lack remains in the field of prophylaxis and prevention–how to tackle this remains our biggest challenge, not only for adolescents but for the whole field of psychiatry.

Educational Problems in Disturbed Adolescents

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Emotionally disturbed adolescents, with respect to their learning experience, come to psychiatric consultation with greatly varying degrees of achievement. If one sets aside the group of mentally sub-normals who by and large has already been recognized before it reaches adolescence, and for whom special training curricula are known (whether they are implemented or not), the teaching of these patients meets two groups of problems: inhibition of the intellectual potential, and reaction to the school situation.

Regardless of the risk of an academic lag, it is hard to see any therapeutic value in interrupting for any length of time school attendance of some kind, except perhaps during brief psychotic episodes (and it is well known that these are generally brief in adolescence). Learning habits are and must remain part of the reality world of child patients: as well exemplified in the treatment of school phobia. Furthermore if the therapeutic efforts tend as they should, towards normalization of the environment, rather than isolation, the adolescent must be maintained in his peer group and encouraged to take part in all the activities which his friends outside the psychiatric institution regard as their daily routine.

School is an important part in an average adolescent's life. The attitude of the parents towards their teenage son, his own self-image and attitude of his peers towards himself, depend a great deal on his academic achievement. It is also recognized that the very same attitudes described above play a significant role in the development of delinquent behaviour in an adolescent. The close relationship of learning problems, achievement of grades and delinquent behaviour therefore is hard to deny.

In any group of acting out teenagers with normal intelligence certain facts stand out. A great majority of them show poor academic achievement, as shown by the grade reached, majority of them have a marked reading deficit and almost all of them have a poor motivation towards learning. The question then arises, is it the learning problem which is responsible for the poor academic achievement which has resulted in emotional problems at home and school or is it the emotional problems which caused the learning difficulties? The answer to this question as in other areas of psychiatry is hard to find.

The above description does not apply to a hypothetical case, but in the Adolescent Service of the Douglas Hospital, which preferably admits behavioural problems, such a case is the norm rather than an exception. Most of these adolescents have average or above-average intelligence, almost all of them have experienced emotional and social deprivation in their earlier years. In most cases there is a history of truancy, aggressive behaviour, stealing and failure in school. They all have a poor motivation towards learning. Neither extrinsic rewards nor inner satisfaction seem to be the factors which one can use to alter the motivation. Poor self-image and a complete indifference to the future seem to be the characteristics of these adolescents. With such odds loaded against one, success in treatment seems to be a hopeful delusion. However, if one takes full regard of the causative factors and makes a careful assessment of each functioning area of each adolescent, a broadly based treatment approach has a reasonable chance of success.

A residential treatment facility for such adolescents must help the adolescent in his interpersonal emotional problems and at the same time deal with his cognitive difficulties. In most cases success in one area leads to improvement in the other. If one agrees with Stulken's definition of education "as a process by which the behaviour of children is improved, that they may think, feel, and act differently than they ever did before", then the role of the teacher as a member of the therapeutic team is an important one. Increasing number of hospitals are preparing programmes for teaching disturbed adolescents. Besides hospitals there are correctional institutions receiving adolescents from Juvenile Courts. These institutes are providing residential care to acting out adolescents. At present most of these children are hardly given any psychological tests. No figures regarding their reading and learning problems are therefore available.

In community schools according to Kvaraceus "no deviant child among exceptional children suffers more in the way of retaliatory and rejecting attitudes on the part of those around him than does the delinquent youngster." He reports in a study of youth workers including teachers, that of all types exceptional children the delinquent child is the one with which they like least to deal. This is in fact a sad state of affairs because though these youngsters may be difficult and lack motivation, however, they do possess the potential to become successful criminals or tax paying citizens of our community of tomorrow. Very much depends upon the help provided during the difficult years of adolescence.

At Douglas Hospital, most adolescents admitted cannot conform to the educational expectations and pressures of society. The educational programme offered is in some ways radically different from what one would expect at a regular school. Much of the time is spent in trying to assess for each adolescent realistic objectives that can be achieved in a step-by-step fashion, so that eventually he can be returned to society, with the necessary controls and ego strengths which would enable him to function as a part of society.

The school programme in a residential setting for adolescents should therefore consist of in part in determining the intellectual, motivational, and behavioural assets and deficiencies of each patient, and the development of programmes to provide help in these areas if necessary.

Part of the school programme then, is concerned with an assessment of reading and learning skills and abilities. Therefore, it is important for us to describe and define the population of patients we are dealing with in this area, to determine if help is needed, and the kinds of help we can offer.

We have found that in most cases it is unrealistic to expect that these adolescents will go to university, complete high school, or in many cases even return successfully to a regular school programme. Rather we must direct ourselves to the following question: has enough skill and interest been inculcated to enable these adolescents to deal with realities such as job expectation, personal and familial maintainance, and individual intellectual needs and demands?

What follows is an account of the process undergone in devising a reading programme sufficient to meet the needs of disturbed adolescents with a significant academic lag involving both a lack of skills and/or motivation to learn. It is presented here as an illustration of one of many areas which warrant exploration in the education of the emotionally disturbed adolescents; some findings may also be applicable to children.

Fifty-five adolescent girls were tested over a 28-month period. Of these, 49 cases were used since there was insufficient data in six cases.

In order to assess a patient's level of academic abilities and interests, a battery of tests consisting of verbal and non-verbal IQ tests, reading tests, ability and achievement tests were administered. From this information, a programme which could be loaded toward particular academic or non-academic areas was developed, and future goals and objectives were formulated.

The five Gates reading tests, Understanding Directions, General Significance, Noting Detail, Level of Comprehension, and Reading Vocabulary, formed an essential part of this battery.

Mean reading ages were computed for each individual by averaging the results of these tests. A graph (Figure 1) was made, showing the mean reading age, chronological age at time of testing, and the chronological age at last grade completed for each patient.

Also another chart (Table 1) was made which illustrates for each chronological age for the five tests the difference between chronological age and reading age, and between reading age and age at last grade completed.

It seems clear that the lag between chronological age and reading age increases with age, while this trend is not in evidence between reading age and age at last grade completed. It therefore does not seem logical to say that a definition of reading retardation can be based on the difference between chronological age and reading age alone. A significant discrepancy between reading age and age at last grade completed, as well as a significant discrepancy between chronological age and reading age indicates a more serious long-standing problem where the more rudimentary elements of reading are involved. Therefore it is more logical to define reading retardation as a reading age lag of two years or more behind both chronological age at the time of testing and chronological age at last grade completed.

Also the data (Figure 1) indicates that there were no patients with reading ages below age 9. Therefore it is possible to assume that we are not dealing mainly with mechanical failures in reading. That is, specific techniques and skills necessary for reading are for the most part intact. Therefore our concern is with the application of these skills in the learning situation.

The data indicates that there is a trend for reading age and age at last grade completed to merge as age increases, and for the gap between chronological age and reading age to widen.

This would seem to indicate that many of the girls who could make use of their formal education are not motivated to continue educating themselves in this way when so much of their energy must be invested in coping with their emotional problems.

There are 14 girls who fit our definition of reading retardation. These girls have for the most part Full Scale IQ scores in the dull normal to low normal range. (Mean Full Scale IQ, 88.6). Their mean Performance IQ's (91.2) are slightly higher than mean Verbal IQ (87.1). Their information, Arithmetic, and Coding, mean sub-test scores (7.1, 6.4 and 8.2 respectively) are characteristically low as well. It is therefore possible to assume that our definition of reading retardation is a viable one which is supported by the results of previous experimentation, (Altus, 1956).

An attempt was made to see if the reading and learning problems are related to age and diagnostic categories. Jenkins and Hewitt have presented strong evidence that there are three different kinds of behaviour syndromes related to juvenile maladjustment. These are the unsocialized aggressive, the overinhibited, and the socialized delinquent. The unsocialized aggressive exhibits assaultive tendencies, initiatory fighting, defiance of authority, and inadequate guilt feelings. The overinhibited exhibits traits of seclusiveness, shyness, apathy, worry, and submissiveness. The socialized delinquent exhibits a tendency to associate with undesirable companions, to steal cooperatively, to habitually truant from school, and in general identified with a delinquent subculture. Also, psychotic patients (not included in Jenkin's and Hewitt's classification) were used as a diagnostic category (see Appendix C). It is interesting to note that there were no cases of reading retardation in the socialized delinquent category.

Müller and Shamsie made an attempt (to be published) to see if Jenkin's classification system is suported by the EEG findings of these patients. The above result (Table 2) is consistent with their findings, that as a group the socialized delinquents showed more normal and better regulated EEG patterns than those exhibited by the psychotic, unsocialized aggressives, or overinhibited groups.

The socialized delinquent is capable of maintaining social relations, of feeling a certain degree of self-worth, and capable of a certain degree of reality testing. The girls in the other three groups are not adept at socialization, and have little feeling of self-worth. It can be assumed then that reading retardation is a phenomenon related directly to core personality problems, and should therefore be treated as an emotional-academic problem, rather than one or the other in a separate fashion.

Dreikurs (1952) has suggested,

"Corrective measures should not be limited to the area of deficiency, but should be applied to the larger issues and the psychological dynamics underlying this deficiency. The teacher cannot ignore the faulty values of the child, his mistaken self-concepts and erroneous approaches. Efforts to change this should become the essence of remedial teaching. Individual, and particularly group discussions can successfully influence children in changing their values and concepts."

Margolin, Roman, and Harari have stated (1955)

"With emotionally disturbed delinquent children, academic tutoring was unproductive, pure psychotherapy often found the disability a rather persistent symptom and one found clinicians recommending remedial work after the child had undergone an intensive therapeutic experience. In view of this we could not consider the reading problems of the delinquent child apart from his total functioning as an individual. Effective treatment involved a modified psychotherapeutic approach incorporating treatment techniques designed to deal with the child's unproductive attitudes and emotional conflicts, and remedial techniques designed to yield positive emotional experiences leading to a more satisfactory orientation towards reading, school and other areas of maladjustment."

At this point it is necessary to gather together the information offered, thus far, some significant findings in our population are:–

1. There is an increase in the lag between reading age and chronological age, with increasing age.

2. There is a tendency for reading age and age at last grade completed to converge with increasing age.

3. Basic reading skills were found to be intact.

4. An arbitrary distinction was made and the subjects were divided into three groups. Group I is a retarded reading group, based on the fact that there was a significant discrepancy between both reading age and chronological age, and reading age and age at last grade completed. Group II, which includes most of the girls, with a significant discrepancy only between reading age and chronological age not between reading age and age at last grade completed, and Group III, with a reading age lag of 1 year or no lag at all.

5. There are no socialized delinquents in Group I or II.

In considering the above evidence, the following reading program has been put into effect. Tutorial therapy groups were established for Groups I and II based upon the following "talk" or "read" principle. It was explained to the group members that the group leader (teacher) would try to help them discover what could have interfered with their ability to read, and at the same time group members could make use of reading material available to them. The group could either read or talk. If a child blocks, for example, while reading to the group she is asked to describe how she feels at that time, to try to recall similar situations and to try to relate past experiences to present performance.

In both groups the material used as subject matter is of two types: 1. reading matter chosen by each individual. This includes anything from comic books or soft-covered novels which are chosen from books already available, or bought at the local drug store. That is, personal involvement and responsibility with this reading material is stressed.

2. Poems, autobiographical material, and compositions written by each girl, and used by that girl or used by others.

There is a heavier emphasis on subject matter, that is comprehension, oral and silent reading speeds, spelling, handwriting and organization in Group I. There is a heavier emphasis on developing wider reading range in Group II and III so that also included are many of the books found in a regular school curriculum. For both groups, motivation, realistic goal-setting, past and present attitudes are major topics of discussion.

To conclude, this proposed reading programme is based upon the following assumptions established in the body of this paper:

1. Our population of emotionally disturbed adolescents have for the most part intact reading skills. It is the ability to put these skills to use in life situations that is lacking.

2. Three groups of reading level have been determined. There exists a retarded reading group, with both a lack of skills and an inability to put acquired skills into effect; a more skilled reading group with an inability to put these skills into effect; and a small group with intact reading skills which can be applied to new learning situations.

3. A tutorial therapy programme, therefore which takes into consideration each individual's motivation, past attitudes, interests and experiences, seems best suited to remedy the problems exhibited in Groups I and II.

At Mont Providence Hospital in Montreal, another approach has been used with adolescents with similar problems. The subjects of the regular curriculum were broken into 10 color-coded groups of cards (the total number of cards reached 55,000). Each card presents the child with a single problem, question or statement which he must comprehend, solve or work at before he can proceed to the next. On assignment, the student undertakes to "study" a number of cards as a sort of contract with himself rather than in competition with others. Books become mainly sources of reference instead of material to be memorized.

The above attempts indicate that it is possible to devise programmes which will help the emotionally disturbed adolescent with his educational problems. However the teaching programme might be seen as an essential part of the total therapeutic approach and teacher must be fully integrated in the psychiatric team.

The emotionally disturbed adolescent is capable of learning. He has learned in some way, however unsuitable, to cope with unhappy situations. Unfortunately, these coping mechanisms have interfered with his ability to function in a manner prescribed by society. If a child learns that socially prescribed communication is for the most part unpleasant, unproductive, and unrewarding, then it will be avoided. It is our job to demonstrate over and over again that long-established inappropriate learning patterns are invalid and unnecessary. This implies that we do not accept intelligence, motivation, skills and abilities as static entities. We must therefore through understanding the individual needs and nature of each student's past and present problems plan realistically for future growth.

This paper has been rewritten for this publication. Parts of this paper appeared in the Canadian Psychological Association, publication, Reading Difficulties in Children, Vol. 9, No. 2. Apr. 68., in the contributions of S. J. Shamsie and H. Boudin.

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Figure 1
Graph showing relationship between Chronological Age, Reading Age, and Age at Last Grade completed for 49 female adolescent patients at Stearns Pavilion, Douglas Hospital

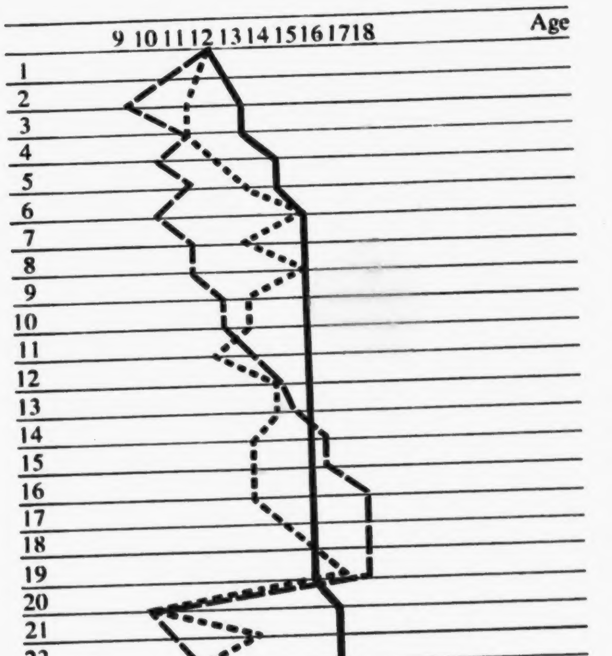

Table 1
The Difference In Years Between Chronological Age and Reading Age (Column A), and Age at Last Grade Completed and Reading Age (Column B).

Chronological	The 5 Gates Reading Tests									
Age	Understanding Directions		General Significance		Noting Detail		Level of Comprehension		Vocabulary Reading	
	A	B	A	B	A	B	A	B	A	B
15	–1	0	–2	–1	–1	0	–1	0	0	+1
16	–2	+1	–4	–1	–3	0	–4	–1	–1	+2
17	–4	–2	–5	–3	–3	–1	–4	–2	–3	–1
18	–4	–1	–4	–1	–4	–1	–3	0	–3	0

Table 2
The Distribution of Readers in Relation to Jenkin's Behavior Categories (including Psychotic) and Age*.

Chronological Age	Unsocialized Aggressive	Overinhibited	Psychotic	Socialized Delinquent	Ratio of Retarded Readers to total in each group
12	1	0	0	0	0/1
13	2 $\boxed{1}$	0	0	0	1/2
14	0	1	1 $\boxed{1}$	0	1/2
15	3	8 $\boxed{3}$	1	2	3/14
16	4 $\boxed{2}$	3 $\boxed{1}$	1	5	3/13
17	3 $\boxed{2}$	2 $\boxed{2}$	3 $\boxed{1}$	1	5/9
18	0	3	3 $\boxed{1}$	2	1/8
Ratio of Retarded Readers within each category	5/13	6/17	3/9	0/10	

*The boxed figures indicate the number of retarded readers within a particular cell.

Adolescent in the Family

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Psychological theories about the adolescent often give insufficient attention to his environment. To understand the adolescent, it is necessary to focus upon his interpersonal relationships as they are influenced by his intrapsychic instability. This influence is best seen in his relationships to his family.

The changes of adolescence affect the entire family unit. The family as a whole will undergo phases of considerable instability as it adapts to the changes in the growing child. New methods of obtaining satisfaction and of maintaining equilibrium must be discovered both by the child and by his parents and siblings.

I will illustrate how this model can be applied to:

1. The understanding of certain specific characteristics of adolescence.
   a. Independence and autonomy
   b. Physical maturation
2. Assessment
3. Therapy

1. a. The adolescent's demand for increased independence and autonomy.

During adolescence there is an acceleration of the lifelong process of separation. Typically, the adolescent demands increased independence and control over his actions. He insists upon his choice of friends, clothing, food, hours, work habits, etc. He will provocatively criticize restrictions that are placed upon him and question limits. Although unsure of his own convictions he will often defend his position with apparent certainty. There would appear to be a need to argue and a desire to test out his ideas in familiar surroundings. Parents often perceive this as negativistic, but it is also a constructive testing of reality. He challenges his parents' ideas and demands explanations. He argues the same questions repeatedly. Since generally he knows the answers which will be given, the adolescent is actually seeking exchange as an adult rather than searching for information.

Some parents are able to participate eagerly in these exchanges and are pleased to be able to assign increasing amounts of responsibility to their children. Others cannot tolerate the stress. The demands to re-examine their own convictions open up previously suppressed areas of conflict and may expose differences between the parents or otherwise challenge their relationship. If the questioning is perceived as threatening their positions of authority, they may react with increasingly suppressive rigidity. When this happens, a situation of antagonism may arise to which the adolescent responds by impulsively testing out his power through behavior, rather than through verbal explorations.

Should the adolescent better his parents in these arguments, he may experience considerable anxieties. Though he outwardly resents and opposes their authority, he does not easily give up the fantasy of parental omnipotence. He does not want to see that his parents are vulnerable, and that they have worries and failures of their own. So long as the parents are seen as omnipotent, they are potentially capable of protecting the adolescent from all dangers and of supplying all his needs. He wishes to destroy the fantasy of the omnipotently prohibitive parent yet to retain that of the omnipotently gratifying one. This is not possible. Thus, one often sees wild fluctuations in the adolescent's behavior towards his parents, as he swings from attack, to support and reparation, from adamant demands for autonomy, to regressive childlike dependency.

These fluctuations are confusing and threatening, but through these repeated confrontations with his parents the healthy adolescent gradually relinquishes his fantasies of parental omnipotence and replaces them with more realistic images of himself and of his parents. Simultaneously, the parents become aware of the changes which are taking place in the child.

The more the parents have tended to "live through" their children, the greater will be the sense of abandonment as the children manifest their independence. Many devices such as belittling, pleading, prohibitions, bribery, and the provocation of guilt are employed by some parents to slow down or to reverse this process.

In cases where the adolescent has functioned as an intermediary between his parents, his absence may bring them into direct confrontation with each other. Where this leads to increased parental discord, the adolescent can react with guilt and anxiety if he attributes to himself the responsibility for the anxieties, frictions and depressive reactions of his parents. If his guilt and anxiety, related both to the stresses of autonomy and the parental reaction, become too intense, he may temporarily give up his strivings for autonomy. Alternately, he may aggressively renounce all association with his family. Frequently, there are phases of experimentation with different alternatives accompanied by wide variations in mood, which is characteristic of adolescence.

The following case illustrates how an adolescent's striving for increased autonomy involved the family.

Michael, age 15, was brought by his parents who said that he was not putting effort into his school work, and he seemed disinterested and disobedient. His mother complained that he did not report to her after school and that he stayed out too late. Michael insisted that he was not doing anything wrong, but he felt mildly guilty that his mother felt so hurt.

It was difficult at first to be clear why the parents had requested treatment since Michael did not seem to have any major problems and his rather mild demand for increased independence was certainly not excessive for his age. It became evident that even his reasonable assertions aroused excessive separation anxiety and depression in the mother. She hoped through therapy to maintain the status quo or even to return to the situation of the previous year when she had been able to insist that Michael never be left alone at night without a baby sitter. She was disappointed that Michael did not show her the same sort of enthusiasm, interest and affection as he had previously when she would return from short vacations. He was now content to say "hi" while continuing to watch television or talking to friends, instead of greeting her warmly at the door, showing excitement, and kissing her.

The father was a successful businessman, always working or travelling. Over the years, the mother had focused upon her children to gratify her needs for companionship and warmth. This solution had never been totally satisfactory and periodically her anger towards her husband would erupt. Still, a relatively stable equilibrium had been established. As Michael began to move away from her, his mother began to place more demands upon her husband, who was unwilling to satisfy them. There then evolved an unconscious collusion between the parents to resist Michael's efforts towards autonomy. The problem was not only the intrapsychic *changes of adolescence, but also the difficulty of other family members in finding new patterns of interaction and new means of gratification.*

Younger siblings also may be greatly influenced as the older ones move away. In one family where one of the parents had been in concentration camp during the war, the elder of two sons had had many persecutory anxieties during latency and early adolescence. The symptoms disappeared with treatment, but afterwards his younger brother began to express similar fears of poisoning, of asphyxiation by automobile fumes, and he had many morbid thoughts related to concentration camps. He had taken over the role vacated by his older brother.

b. Physical maturation of adolescence

Sexual maturation and increased sexual drive may arouse conflict not only in the adolescent, but also in his siblings and parents. For example, the mother of an adolescent boy experienced intense anxiety whenever her son's friends would come to visit. She knew that they were "examining" her and it frightened her to be aroused by them. She responded to this by attempting to avoid her son and his friends as much as possible.

Parents may experience the reawakening of wishes and fears from their own adolescence. They may attempt to gratify their own needs vicariously through the children while retaining the outward role of prohibitor. The following short example illustrates the manner in which parents can provoke acting out while at the same time forbidding it.

The father of a 13 year old girl complained that his daughter was "hanging out" with motorcycle gangs. He was afraid that she would get into trouble sexually. At times he would follow her and watch while she went into a building with these boys. However, he did not actively interfere. Though the father verbally prohibited her sexual activity, his own curiosity stimulated her and his failure to protect her was a form of implicit acknowledgment and assent.

This type of interaction can be extremely difficult to treat. If one attempts to deal with the sexually acting-out adolescent in individual therapy, then it is not possible to control the stimulation from the parents. However, the parents are usually unaware of their role in the interaction. It is often best to see the family as a unit and to be frankly directive, pointing out the lack of consistency in the parents' attempts to set limits, and the provocative limit-testing by the adolescent, rather than to deal too explicitly with underlying sexual fantasies. When treatment is well established this material can be dealt with then if necessary.

Sexual rivalries can arise between parents and their adolescent children. The adolescent girl is often as flirtatious towards her father as towards others. If the father encourages this he contributes to feelings of rivalry and resentment between mother and daughter. The sexual maturation and increasing attractiveness of the daughter may provoke feelings of discouragement and an awareness of aging, with its accompanying diminution of sexual attractiveness, in the mother. This situation can provoke feelings of resentment, self-depreciation, guilt and depressive reactions in various members of the family. The capacity of the husband to respond to his wife's increased needs during this period is important in helping her to deal with her feelings of rivalry and loss of self-esteem.

Physical maturation is accompanied by changes in status and role. The adolescent demands the status accorded a man or a woman. Often, he assumes some of the parental executive, disciplinary and leadership functions. Although this may produce conflict, it can also greatly strengthen the family unit. These changes in role behavior necessitate restructuring of the relationships within the family.

2. Assessment of Adolescence

In assessing adolescents it is readily understandable that conjoint family interviews will often provide information which could not be obtained by any other means. No amount of history taking from the patient or from other members of the family can replace the observation of the family as a unit. The immediacy and the impact of the actual interaction provide a vivid mental picture, which is invaluable in further therapy, whether this therapy will be of the family unit or of the identified patient alone.

This would be true for most patients, but is particularly applicable to children and adolescents, where behavior is often more informative than words. The usual sources of information–historical reconstruction, introspection, and transference phenomena, are of more limited value in assessing adolescents than is true with adults, for the following reasons.

The adolescent often lacks pertinent historical and factual information. His descriptions are too narrowly self-centered to allow the interviewer to build up a composite picture. The adolescent is often confused and cannot understand what is happening to himself and to his family. He frequently reacts with silent irritation or rejection when asked to describe what is beyond his comprehension.

Introspection is initially felt by him to be useless and frustrating. He wants action and gratification; not words. Often he lacks the facility to express himself clearly. His silence may also reflect his antagonism at being singled out as the sick one. He may feel persecuted and picked upon by a hostile environment, particularly by his parents, and he tells us that the difficulties are not his problems alone. Therefore, to interview him by himself may indicate to him that the examiner accepts the parents' evaluation of the problem. No amount of assurance of neutrality by the interviewer can overcome this conviction. The adolescent will feel that he is being "conned."

The third usual source of information, transference, is difficult to interpret to the adolescent. He may be fiercely dependent and demanding, but at the same time he insists on keeping his safe distance. Closeness to the therapist may threaten his shaky identity and sense of self. It is often best to respect his need for distance and to avoid too early exploration of transference.

The following example may illustrate the value of a diagnostic family interview in the assessment of an adolescent problem:

Ken was a 13 year old boy who spread rat poison over the walls of the school. Two weeks previously he had told his mother that he had attempted to commit suicide by swallowing some silver nitrate. There was a previous history of petty stealing and of running away from home.

The immediate problem was whether to allow him to continue at school. He was seen in an interview together with his parents.

There was a great amount of tension between this couple which they had attempted to deal with by avoidance of each other. The father worked all day and the mother for several years had worked on a night shift. Thus, they were seldom together. They rationalized this on the basis of work requirements, but in fact neither had attempted to arrange the work schedules so that they could spend time together.

Ken hardly said a word in the interview. He's one of those boys who are virtually non-verbal. However, his posture and his expression indicated that he was extremely involved and responsive. As we explored the difficulties within the family, Ken would nod his head in agreement or disagreement.

The interview revealed that the growing awareness brought on by adolescence had enabled Ken to perceive the precarious state of the family relationships. Characteristically, he was a boy who expressed himself through behavior. The very dramatic episode with the rat poison represented an attempt on his part to attract attention to the deteriorating situation within his family. It was his desparate plea for help.

When this was suggested to the family he nodded his head in agreement. It was recommended that he be allowed to continue at school, since it was an important stabilizing feature of his environment; to suspend him would only involve him more deeply in a tense home situation. Once the school had responded adequately to his plea for help, it was unlikely that he would have to repeat it. Conjoint family therapy was also recommended.

It is especially important in family interviewing to attend closely to non-verbal communications. This is particularly useful with those children who are negativistic or who are inhibited, as is commonly seen in adolescent boys. Without obliging them to talk and by commenting on a non-verbal cue, they can be given a sense of active participation in the interview. The presence of all the family members at an interview often makes it possible to come to an understanding which cannot be achieved by interviewing the adolescent alone, and wherever possible the family should be seen as a unit for at least the initial assessment.

3. Treatment of Adolescents

Bettelheim states that "the problem of the generations is an inter-personal difficulty. Therefore, to deal with it as if it were intrapersonal only complicates matters instead of simplifying them and makes resolving them less likely." What then are the indications for conjoint family therapy as opposed to individual therapy for adolescents? By conjoint family therapy I mean that the entire family including the patient, is treated as a unit and is present at the sessions at the same time. There are no absolute criteria to determine the method of treatment, but I have found the following considerations to be helpful in the deciding upon the treatment plan.

1. Early or late adolescence. There is such a difference between early and late adolescence that it is doubtful whether they should be grouped together under one heading. In general, the older the patient, the greater the indication for individual treatment. Often this is the only choice that he will allow. He may look upon a recommendation for family treatment as an attempt to force him back into the family fold and he will flatly reject it.

Commonly there are sexual problems which he will not discuss in the presence of other family members.

2. The silent adolescent. The silent nonverbal adolescent often responds best to family or to group treatment. Individual therapy frequently becomes an ordeal of embarrassed silence for both the therapist and for the patient. It is interesting that very substantial progress can take place without the identified patient ever having said much about himself. These patients are often confused prior to treatment, and they benefit from the clarification which takes place during family sessions. It is useful to encourage them to put ideas and feelings into words without making them feel compelled to do so.

3. Problems of vicarious stimulation. Family sessions are useful where the parents stimulate, consciously or unconsciously, the unacceptable behaviour of the adolescent. These parents derive their greatest satisfaction through the behaviour of their children.

4. Problems of separation. When separation arouses excessive disturbances, the therapist can play partly an educative and partly a supportive role. He can help the parents to deal with their anxieties, their depressions, and their fears of aging. He can help them to reorient themselves toward each other or towards other interests. The therapist must help them to relinquish their child.

He must also protect the adolescent against attempts by his parents to infantalize him, and at the same time the therapist must protect the parents against unreasonable demands by the child by assisting them in establishing firm limits. At the same time he can help the adolescent to deal with anxieties and guilt and thereby limit regressive, impulsive, and aggressive behaviour. Once the adolescent realizes that the therapist does not intend to block progress, the groundwork has been made for later individual help if this should prove to be necessary.

5. Problems of manipulation. When an adolescent manipulates the family through his symptoms, especially through threats of self-destructive behaviour, the therapist can assist the family in dealing with these threats realistically. For example, parents are often unwilling to utilize the courts, and the child may play upon their feelings of shame, humiliation, and helplessness. If he should succeed in destroying his parents' capacity to realistically advise or control him, he makes his own position all the more dangerous. The therapist may have to break this cycle by temporarily taking over the parental function of control and by reinforcing their ability to withstand manipulations.

6. Hospitalization. Family therapy is commonly indicated when hospitalization of the adolescent is necessary. The therapist can help the family to deal with their guilt and self-recriminations. More important, changes in the family structure are necessary to allow the patient to move back into it after hospitalization. If the patient returns to the same environment which fostered the illness, if nothing is altered in the pathogenic home setting, the same processes which led to the original hospitalization may occur.

Lastly, it should be emphasized that the purpose of conjoint family therapy is not only to deal with family psychopathology, but also to utilize the family's strength in the treatment process. Various members may prove to be essential therapeutic allies. An older sibling is often the first one to gain insight into the difficulties and can offer very useful support to the patient or to other family members. Sometimes it is a useful therapeutic technique to encourage the healthy sibling to make interpretations which the family will accept more readily from him than from the therapist.

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Adolescent in Juvenile Court

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Children and adolescents appear before the Juvenile Courts primarily either for protection or for committing delinquent acts. The distinction between a "neglected" and a "delinquent" child is often an artificial one. Most children appearing before the Juvenile Court for protection do so because of excessive truancy, home desertion and uncontrollability, or unmanageability. With such children a shop-lifting, cycle theft, even car theft incident is often almost accidental, merely another expression of the same rebellious, uncontrolled, acting out behaviour.

Laws concerning minors are based on the premise that the children are, in the nature of our society, essentially helpless and dependent, and therefore, in need of care and protection. Children in difficulty, delinquent or "acting-out neglected" are considered in need of society's help rather than meriting its retribution. Aichorn emphasizes the same point when he states, "we are of the opinion that such circumstances do not justify society in singling out the innocent victim, the wayward youth, on the shallow ground that it is him and through him that other people's defects are exposed and their errors brought unpleasantly to our attention." In most cases appearing before the Juvenile Courts after a careful history taking, it becomes apparent that the real problem is with the adults. In those families where it is hard to find any pathology which will explain the antisocial behaviour of the adolescent, it is usual, in such cases to use such concepts as "super ego lacunae" and "double-binds" to explain what is not evident. Johnson and Szarek have suggested that antisocial acting out in a child is unconsciously fostered and sanctioned by the parents, who vicariously achieve gratification of their own poorly integrated forbidden impulses through a child's acting-out. Without denying the validity of such concepts, it appears that there is a reluctance to accept that an antisocial adolescent may come from a "normal" family. However, it is possible to conceive that a child may have an intrinsic defect such as poor conditionability and may require a greater number of reinforcements to establish a conditioned response, which could account for his poor socialization, if socialization is seen as a learning process.

Law and the Adolescent

Delinquent Act is defined differently in each country, taking Canada as an example, the Act defines "Juvenile Delinquent" to mean "any child who violates any provision of Criminal Code or of any Dominion or Provincial statute, or of any by-law or ordinance of any municipality, or who is guilty of sexual immorality or any similar form of vice, or who is liable by reason of any other act to be committed to an industrial school or Juvenile reformatory under the provisions of the Dominion or Provincial Statute." This is a very broad definition. One has to recognize that every young person inevitably violates some ordinance or law while growing up. All such persons certainly do not fall within the popular conception of a Juvenile Delinquent. The Juvenile Courts will be soon overburdened if all Juveniles who committed delinquent acts were brought to their attention. In fact it is hard to conceive a way in which an emotionally disturbed adolescent can show disturbed behaviour without his violating some municipal, provincial or federal law. Thus, if an adolescent gets fed up with the impossible situation at home and runs away, this could lead to his appearance before the Court. If he is depressed or suffers from school phobia and stays at home, absence from school could lead to his appearance before the Court. If his family abandons him, he may appear before the Court for the sake of protection. Therefore many adolescents appear before the Court who are not "delinquent" and have not exhibited any antisocial behaviour. All this may be justifiable if every juvenile court had the services of a well staffed psychiatric clinic for proper assessment of each case and if every institution for juvenile delinquents was providing high levels of social and medical care. This unfortunately is not the case.

Adolescents appear before the Juvenile Courts for behaviour in which adults could indulge with impunity. This discrimination, David Matza has suggested, could in itself be a cause of delinquency. The broad definition of Juvenile Delinquent Act, the wide powers given to the judge were aimed at offering adolescent offenders individualized justice and treatment rather than impartial justice and punishment. However at present in most cases there is little possibility of gaining an understanding of each adolescent appearing before the Juvenile Court, and certainly no possibility for adequate treatment. Juvenile Courts have up to the present time failed to fulfill the aim, due to the lack of adequate assessment and treatment facilities. Therefore more often than not an adolescent appearing before the court comes to react to the adult world with an increased sense of injustice and a decreased sense of social responsibility.

This becomes more apparent when one considers the socio-economic factors. The Juvenile Court system is especially more discriminatory against members of the lower socio-economic classes. An adolescent coming from an upper social class may be able to avoid the appearance before the Court, while an adolescent from the lower socio-economic class more often than not ends up in a correctional institution, with an indeterminant sentence. If the correctional institution provides high level of social and medical care, this will not be a serious disadvantage. At present most such institutions provide nothing more than food and shelter under a rigid and authoritarian system. One has to recognize that unless facilities are adequate, institutionalization may have a detrimental effect on the rehabilitation of the offender.

Another especially frightening aspect of the Juvenile Court system is that an adolescent confined to a correctional institution may be transferred to an adult institution if his behaviour causes disciplinary problems. This practice, as stated by Sheridon, a leading American authority on Juvenile Court legislation, is unsound both legally and socially. Not only does it deny the transferred youngster who thus becomes "prisoner", the protection of criminal proceedings but it also undermines the philosophy of the whole Juvenile Court movement, which was established primarily to protect the child from contacts with adult criminals.

The delinquent act may represent the cry for help, the failure of growth and development of the child or an expression of anger and hostility towards the inmediate environment. Aichorn emphasizes that "the waywardness and criminality of juveniles should be interpreted merely as a consequence of crises in upbringing which comes from retardation in the child's development or regression to an earlier stage. Without examining any particular expressions of delinquency, we may learn from two features present in the make up of each and every delinquent and criminal, and point consistently to a discrepancy between actual age of the person and the phase of development he has reached. These two features are the following, the presence of an irrepressible need for immediate gratification of instinct, and the fact that such moral rules as are valid in society have no compelling force for the individual concerned."

The Juvenile and Family Courts are in most instances and should be in all cases the community's instruments for providing or initiating the help the child and adolescent needs. With this definition of the role of the Juvenile Court, the need for a psychiatric clinic attached to the court to properly assess each case becomes evident. At present most Juvenile Courts have the possibility of getting a psychiatric assessment when they so desire. The problem is in the time which it takes to get a psychiatric assessment. Most clinics which provide this assessment have other important commitments.

The other severe defect in the present situation is that the psychiatric help comes to a dead stop after the assessment has been made available to the Juvenile Court. It is not rare to find as many as three to four psychiatric assessments on one child in the course of one year, each assessment giving detailed dynamics of the child and the family, recommending psychotherapy or family therapy and the child still locked up in a detention centre as the court is unable to find the treatment facility. Most clinics providing the assessments and recommendations do not involve themselves in any follow up. This results in adding a few more pages to the dossier of the child, each time an assessment is made but no real progress towards helping the child or the family.

Incidence of Juvenile Delinquency

In its report on Juvenile Delinquency in Canada, the Canadian Department of Justice Committee on Juvenile Delinquency points out that between 1957 to 1965 while the population of Canada increased by 9.5% and the Juvenile population (under the age of 16) by 11%, Juvenile Court delinquency appearances increased by 17% and the number of judged delinquencies by 27%. The figures for other countries are no different. In U.S. there has been a steady climb in the incidence of juvenile delinquency. The percentage population of the young has been increasing. According to statistics of National Institute of Health, by 1968 about 50% of the whole U.S. population will be under 25 years of age. Present facilities are poorly staffed, ill organized and overcrowded, and even if there is no increase in the incidence of juvenile delinquency we are ill prepared for the future increase of adolescents in our population.

Characteristics of Adolescents Appearing Before the Court

Most adolescents appearing before the Juvenile Court fall into three types described by Jenkins, namely, overinhibited, unsocialized agressive and the socialized delinquents, and they tend to come from families which are repressive, rejecting or neglecting respectively. It seems necessary that adolescents should be classified not according to the delinquent act, they indulged in, but according to their personality structure and the family backgrounds. For each one of the above three types could, for example, appear before the court for stealing. Beyond the act of stealing, there may be little similarity between these three adolescents, and each one of them will require a different treatment approach.

The overinhibited adolescent may have no previous history of antisocial behaviour. He may show excessive anxiety. There may be strong feelings of guilt. He may have difficulty in expressing his feelings. His academic record may be satisfactory, and he may have no real explanation for stealing except that the extremely rigid and restrictive environment was becoming intolerable. This adolescent will do well with psychotherapy and family therapy. He would require hospitalization or institutionalization only if there are serious suicidal ruminations or if the family is entirely uncooperative. Here the act of stealing must be seen as an unconscious attempt to get help.

The unsocialized aggressive adolescent may also appear before the Court for stealing. There may be a history of overt family rejection. He may have been in a series of foster homes or institutions. The history of difficult behaviour, temper tantrums, defiant and belligerent attitude, stealing, truancy, may go back to younger years. This adolescent will present an aggressive and hostile attitude with very little anxiety or guilt. He will explain his stealing as simply wanting the stolen object, with little thought of the consequences. Here the act of stealing must be seen as an impulsive act of an individual with few inner controls. The lack of socialization being the result of early rejection and poor identification. This adolescent in most cases will need to be hospitalized or institutionalized so as to provide consistent controls in an understanding environment, so that it becomes possible for the adolescent to synthesize a super-ego.

In a socialized delinquent stealing may indicate a defiant and testing attitude towards the adult society. He may be involved in stealing as a gang activity. This adolescent shows that he has controls and is socialized, however, due to neglecting attitude of the parents who usually come from middle class, the adolescent has identified with the delinquent minority. There may be other problems such as truancy, drinking and taking of drugs. There will be a lack of meaningful communication in the family. The crisis of identification, to which Erikson refers is evident in these cases. Majority of adolescents have to be treated away from the family. When removed from the delinquent friends, anger and hostility soon change to depression and therapeutic process becomes possible.

The above is stated to underline that adolescents may appear before the Court with the same charges of stealing, but each may have a different dynamic personality structure, may come from a different family background and will require a different treatment approach.

Need for a Juvenile Court Clinic

Though majority of adolescents who appear before the Court fall into the three types described, there are cases of psychosis. Diagnosis of schizophrenia in adolescents is very hard to make especially when it is in its early stages, and there are no clearcut primary symptoms. There are also cases of organic pathology, mental retardation and reading problems. In fact, through the doors of a Juvenile Court in one year passes all the psychiatric disorders known in children and adolescents. This emphasizes the need for a well-staffed psychiatric clinic attached to each Juvenile Court. This clinic should not only make assessments and recommendations, but should also be responsible that the recommended treatment is carried out after the Court has approved the recommendation. The Clinic should have no other commitments except to the Court and a good working relationship with all the community facilities including correctional institutions.

Treatment Approaches

Though psychotherapy, family therapy, milieu therapy and group therapy are the main therapeutic tools in working with disturbed adolescents, the value of drugs must not be underestimated. In controlling anxiety, reducing aggressiveness to tolerable limits and treating depression, drugs are of invaluable help. There are though certain areas of caution when using drugs with these adolescents. It is preferable to use phenothiazines to control anxiety and tension than minor tranquillizers. Firstly, in our experience we find phenothiazines more effective in controlling agressive behaviour than other drugs, secondly there is always the risk of addiction with other anti-anxiety drugs. When choosing a phenothiazine it is preferable to use one which causes least drowsiness and extrapyramidal symptoms. Adolescents seem to resent these two side effects more than adults. In the choice of an anti-depressant it is extremely dangerous to use monamine-oxidase inhibitors. It is unreasonable to hope that acting-out adolescents will observe the necessary precautions which are indicated with these drugs; with other safer and effective antidepressants being available, there is no real justification for taking the risk.

Conclusion

It has to be recognized that adolescents appearing before the Court can only receive proper treatment if each adolescent can be properly evaluated and if varied and adequate treatment facilities are available in the community. In recent years there has been an increase in the population of young people and consequently there is an increase in adolescents appearing before Court, and being referred to Hospitals and Clinics. To provide adequate treatment for adolescents there is a need for outpatient and inpatient treatment facilities in hospitals, treatment oriented correctional institutions and group foster homes. Only with a spectrum of facilities extending from closed correctional institutions to group foster homes will it be possible for each adolescent appearing before the Juvenile Court to receive appropriate treatment.

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Adolescence as Rebirth

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This paper concerns itself with stereotypes and it is a truism that the further away one is from a group the more readily one identifies it in terms of its stereotypies: Scotsmen drink whisky and play bagpipes; the French eat snails; the Dutch are clean, etc. (Often and sadly most characteristically stereotypic descriptions are less complimentary to the group described). In most of these loose descriptions by category there is either some obvious direct truth which accords immediately with an observable reality, or else there is an invitation toward a truth about the group, some partial perception which when teased out can become an Ariadne's thread leading one painfully to a central problem of history and culture which defines the group beyond the crude simplicities of the initial statement.

Not only there are stereotypies of social groups, there are also stereotypies of historical group. And while the stereotypies are probably not easy to elicit I think they will help in the making of my point. Thinking of Classical Greeks what comes to mind, or rather who comes to mind? For me young athletic kouroi, those battalions of muscular young men, sometimes fainly epicene, or a bearded worthy in a white robe; a man of the far side of middle age. And unless one is a scholar there are few Greeks of simple portliness with bald pates and disappearing rectus abdominis muscles who enter into the stereotype. If one conjectures about the word Elizabethan one ends up with a figure who blends disproportionately a playwright and aristocratic pirate, but old men and youths are excluded. Victorians condense into bearded authors of multi-volume seminal works; the culminations of hard obsessional scholarship, puritanical, self-important, dully monumental and for me frankly enviable. Asked for a stereotypic mid-twentieth century North American, the automatic person who might emerge is the young adult or the adolescent. Other people are certainly in the landscape, but they figure less and I use the word figure literally. The figures in the landscape, on the billboards, in the magazines, or in the learned journals are frequently adolescents. Indeed the indentity of the unfigured, the non-represented multitudes, becomes subsumed under the iconic image of all us–the adolescent. The point of reference, is the adolescent; his vigour, freedom, dancing, costume, causes and confusion. He makes the scene and he is the hero. In the sense that the hero is the concentrate of a society's aspirations. And our heroism in a time of falling frontiers, dead gods, and plenty of money is the public pursuit of what used to be a private chimera: Identity. The adolescent in short becomes defined by stereotypies used not only to describe him but a whole society.

There is then a continuity to identity between the adult and the adolescent, at this point in time, in our society, which while unique, could only exist if the biological potentials were there. Adolescence has taken on a widely extended meaning. Certainly the process by which the pubertal and post-pubertal person came to terms with himself and his society has always been adolescence. But the long extended moratorium during which actions had the character of game and rehearsal, was in the past reserved largely for aristocrats who could pursue the identity game, during which they discovered their desires and talents, at Oxford, Cambridge, Heidelberg and so on; make the grand tour, sow their wild oats, until they returned home to take their places managing family affairs or "going into politics." The lack of economic and social leeway for the majority prevented the luxury of self-exploration during a period of encapsulated licence. Farm boys, apprentices, young sailors, quickly passed their *rites de passage* into adulthood. Who they were, was a question they rarely asked of themselves. There was, of course the area of private virtue, during which they battled with their desires vis-à-vis the explicit statements of the church, but this sense of sin virtue is only a fragment of the meaning contained within the concept Identity.

Adolescence is not a psycho-biological state defined by sure limits of developmental stages, as for example infancy is. One knows within a fairly well-defined time span when infancy has come to an end. The offset is fairly definite. The child begins its independent life away from mother's breast or substitutes for it, begins to walk and talk, and is clearly no longer an infant. The unfortunately labelled stage of latency ends similarly, and more dramatically with the biological upheaval of puberty. But who would define the end of adolescence. Of puberty there is no doubt; and there are accurate charts of the progressive sequential emergence of body hair, primary sex characteristics, secondary sex characteristics, blood hormone levels and so on. But adolescence which is the total organismic response in psychological, sociological and biological terms to the phenomenon of puberty does not end sharply. Depending on the authority various life events can be signalled as the end of adolescence. As Richard Hoggart vividly described for the working-class boy in England adolescence ended with the first wage envelope, at perhaps the age of fifteen. For a Masai youth it was the killing of a lion, and for the youths of various primitive tribes, it could be variously circumcision rites, or initiation ceremonies into the pathetic secrets of the tribal elders. Each society chooses its end-point according to its mores and potentialities. Adolescence flows into adulthood, and its termination is not a biologically district boundary.

If one accepts that the later part of what we term adolescence is continuous with adulthood in fundamental psychobiological terms, and that it is not a separate definable life stage then certain theoretical consequences follow. Particularly one might question if the detailed dynamic constructions appertaining *only* to adolescence are entirely accurate. Is Erikson's statement that the primary life task of the adolescent is the achievement of an identity as opposed to identity diffusion completely valid? Are Anna Freud's description of adolescence–the organization of defences against an upsurge of puberty–induced instinctual drives unique to adolescence? Their formulations as those of Blos and others carry the implicit assumption that adolescence is an encapsulated life stage with tasks as definable as learning to walk and talk.

Deriving from the theoretical position that adolescence is a defined life stage have been attempts to derive a specifically adolescent complex of psychopathology. We all know the terms "Adolescent turmoil," "Adolescent adjustment reaction," and certainly the hallowed "Dementia Praecox." These pathological entities are supposedly unique to adolescence. Characteristic formulations speak of "The fluidity of defences in adolescence." Or another phrase coming up in ward rounds is "An adolescent is psychotic, neurotic, and even well-adjusted, in a highly changeable way from minute to minute." While the boundaries between psychopathological entities, even in adults can be vague, it is assumed that the boundaries are particularly vague for the adolescent.

A recent study by Masterson et al suggests that this viewpoint may not be accurate and that the clinical entities of adulthood should be applied to adolescents. Adolescents who manifest psychotic symptoms and signs should be regarded as psychotic in the same way as the adult patient is. Similarly neurotic problems tend to remain within the domain of the neuroses rather than the psychoses. There is no licence for the adolescent to be normal and display psychotic symptomatology. There is thus not a psychic moratorium during which symptomatology like life roles may be regarded as "not for real."

While it is certainly not scientific in the narrow sense I have tried to remember if any of the frankly eccentric or disturbed adolescents who were my contemporaries had made satisfactory life adjustments in adulthood. It is the only longitudinal "study" of adolescence which I have personal contact with. I cannot think of one. The striking feature that does emerge is the terrible constancy of their development. What seemed to be bravado and freedom in a number of cases revealed itself finally as the anlage of frank psychosis, and minor despair has in at least two cases bloomed into severe neurotic symptomatology. Certainly I can think of friends who had their troubles who have reached adulthood, no happier or unhappier than most, but even in adolescence their compensatory strengths were present. May I give a few brief examples.

Sonya was a beautiful delicate-looking girl who showed her oddities in the Anarchist-Marxist mould. She shoplifted with the rationalization that "all property is theft" and she was entitled to walk out of a store wearing stolen underwear under her street clothes. In the interests of ideological orthodoxy she was the female Torquemada of the group, attacking bourgeoisie backsliding in her friends, with malicious public invective. Ten years later the invective had become paranoid delusions, and the thievery flourished into delusions of owning the goods of the entire world.

Anya was the saint of the group. In the middle of uproar and high-jinks, she smiled quietly. When asked for her opinions she smiled secretly. She developed a reputation for deep wisdom, until she progressed into a withdrawn chronic schizophrenia from which she occasionally remits. During remission she smiles sadly and gently, and if one did not know she could again be thought of as wise and sibylline.

Most people would accept as a statement of the obvious that human biographies are continuous. Whatever the theoretical school, all development is seen as a series of stages each one of which consolidates itself upon, and derives its characteristics from that which preceeded it. Although Erikson carefully defines the life stages and their appropriate tasks, he states explicitly that infantile basic trust contributes to what is encountered during the phase of adolescent identity discovery. Latency is no longer thought of as a period of psychic and physical refrigeration, and Cohen has adumbrated a concept of pre-puberty, which is recognized in certain cultures. The similar continuity of development such as has just been described for the two unfortunate girls, can be constructed for most individuals who come to mind. However while there is a continuity in biography, there are stages of discontinuity, quantum leaps as it were in development, in which the changes in the individual are so gross that it is almost as if a new person filled the identity label the process has been completed. I suggest that puberty is the last of these major biological discontinuous leaps in biography, and that adolescence can be regarded, almost as a rebirth into an adulthood which will define (with greater or lesser variation) the recognisable individual until his death.

To pursue the analogy, the child who is born is not entirely unpredictable. Genetic studies lead one to have certain expectations of hair and eye colouring, size, and even range of intelligence. Increasing evidence accumulates that intra-uterine experiences of the foetus derived from mother's nutritional state, illnesses during gestation, and so on, have a profound effect on the foetus. The gestation period obviously determines the characteristics of the child to be born. However the birth itself is an event of psychobiological discontinuity, and the neonate arrives in the world with a set of endowments, with which he will respond to his world, and which will help himself impose himself on the world. When the infant is born we wait to see, what sex he will be, what size, and for a few years we will observe and encourage the development of emotional, physical and intellectual strengths.

Similarly the adolescent is born through puberty into adulthood. The preceeding years may be regarded as a gestation. During and after puberty the adolescent and the world discover, what sex he really is, what size he really is, how strong he really is, and how talented he really is. It is as though the prepubescent individual gives birth to his adult self.

Perhaps it is possible to apply to the growth processes of adolescence, and all the characteristic behaviour of adolescence, a general theoretical framework, which describes the emergence of any complicated organism into a new environment, and which does not attempt to encapsulate the phase of adolescence into a unique theoretical entity with laws and expectations of its own.

As a crude example let us consider a rat released into a new cage for the first time. The rat trembles for a moment in the corner, and then begins to explore. He finds the range of the cage; how far he can roam. He attempts to jump the walls, and soon discovers how high he can jump. He discovers the source of food and water. During the first exploratory stages his movements are tentative, and alternate between fearful raptus, and timid exploration. Introduce into the cage other rats of the same group (rats which are not immediately murderous towards one another) and a hierarchy of strength will soon establish itself. In more elaborate socially organized animal groups, similar things happen, moose and barnyard fowls and baboons have established patterns for the battle of leadership.

While I am aware of the dangers of extrapolation of animal behaviour into human behaviour and have to wish presumptuously to denigrate the elaborate and rich clinical dynamic formulations of adolescent psychic process, I wonder if this simple analogy might not explain most of the features of the behaviour we now label adolescent. Namely the emergence of an animal into a new environment. In finding his place in the environment the adolescent like the rat has to test his new instinctual, emotional and intellectual attributes against the realities of the world. This will on a priori expectation lead to a sense of newness–that he discovers America for the first time. Art is a sudden revelation, politics appear fresh and soluble with simple actions, causes are exciting. There will be the sense that one can roam the cage to its limits, and if the limits are poorly defined there will be overreaching and inappropriateness. Tests of one's own strength will be made against the boundaries of experience: Is one really a poet or a mathematician, or a prizefighter? What is it one can do?

The discovery of the self proceeds by a process of positive and negative reinforcement from the environment, and in this process we will observe all the characteristics which we now define as adolescent. The enthusiasm, the commitment, the simplicity, the awkwardness, the fearfulness, the inappropriateness, the bewilderment, the erratic changeability. An essential part of the process is the feedback from reality. And reality is composed of internal endowment factors, intelligence, the given degree of psychic intergration, and external boundaries which derive from the mores of the group, and socioeconomic circumstances.

If the limits are poorly defined or changeable then the response to the behaviour of the adolescent will of necessity be ambiguous and weak. The message he then receives from the environment is not one which limits him appropriately and which helps him to determine his limits. Identity is largely determined by limits, by the inner and external injunctions of "This I may do" and "That I may not do." I would suggest that in the absence of emotional, economic and social limits the adolescent remains always in the position of the reborn creature, scrabbling agitatedly for a set of defining conditions to the self.

A somewhat superficial definition of an adult may perhaps be that he is an adolescent who has learned what he is. The fewer the limits that a society imposes the less likely is there to be the discovery of the authentic self and the less likely is adulthood. To return for a moment to Hoggart, who has mapped out the characteristics of a working-class childhood, and contrasted it with the middle-class model in England. The middle-class boy maintains the attributes of youthfulness well into his twenties, since his reality does not hem him in to the same extent as the working-class boy.

I would like to return to one of the earlier statements of this paper, that the concept of adolescence now subsumes many more people than teenagers. It absorbs all those who have lost a grip on their own sense of limits, which is at one and the same time, limiting, but supporting. With the loss of central authority (perhaps not as much as we suppose) the adult world has lost much of its limiting imperative, not only for the adolescent but for the adult as well. Instead of adulthood providing the source of authority which will help to organize the adolescent, it now frequently turns to the adolescents for its customs and fashions. There appears to be a hunger for guidance and authority (witness Leary's crude new religion) and in the absence of well-established moral and social limitations, any chance fashion, that is presented with enough strength takes on briefly the attributes of well-established genuine institutions, and both the adult and adolescent worlds are racked by quickly passing fads. If it were not for a huge absence the demigods of the entertainment world could not hold the sway they do, and if it wasn't for the absence of real issues, long hair or short hair could never become the cause that it does.

The adolescent and the infant are hopefully supposed to discover security in the limitations of the wish and the curbing of their fearful omnipotent fantasies. There are–to put it in a square fashion–dangers in too much freedom. In random self-satisfaction, without authoritative guidance. The young in the West used to, and in most parts of the world still do, have the advantage that their untested fantasies would be limited by their lack of economic and social power. Their activities were given the status of games (and a game by definition is an activity indulged in for pleasure, and which has no consequences in reality). In the past when a teenager wanted to run away from home, he got about as far as the corner drugstore, but now if he has a sports car (and I know not all adolescents even in prosperous America have sports cars) with power drive, he can be half way to Vancouver before he cools off. Many more adolescents now have the kind of money in their pockets that previously only young aristocrats had, and they can indulge many desires, which may not in fact be terribly harmful but which leaves them a little bit less defined in their conception of themselves.

Adults of course share many of the same characteristics and derive most of their sense of limitation from banks and finance companies. But the characteristic economic mode is the existence in debt, which carries with it the belief (perhaps) that the day of payment will never come and that everything is free.

The hippies who are now the latest Bohemians, "Beats" and "Last generation," (Every era has a label for its marginals and disenchanteds) in fact make a cult of the world without limit. Psychedelic is their catchword, that which expands the limits of consciousness. They deliberately reject the lessons of squaredom: That things have to be worked for; that there may be enemies in the woods; that most people are not to be trusted; if you haven't earned it you can't have it. They celebrate universal love, and decorate themselves with bells and flowers. They lose limits of time and sense with drugs, they put ten cents in the parking meter and lie down into the street where the automobiles should park. They have stores where everything is free. Their celebrations are notably gentle and orderly. Their forms of social protest are "The love in," "The be in," and "The clean in" in which they tidy up whole frowzy streets with pails of water and mops. They may think that they are rejecting the square world of America, but in fact they are its rightful extrapolation and heirs. After all the constitution gives them the right "to the pursuit of happiness" which is really the right of the physically endowed lusty young. They treat the whole of America like a middle-class child treats his parental home. They wander freely in the streets as if they weren't dangerous, and open the economic resources of their world like a child opening the family refrigerator for his free peanut butter and jelly sandwich. They are–if you like–the American pioneers and prophets of the world of limitless technological plenty. They have made the urban world into their Disneyland, and Disneyland is the place where the wish has become reality.

Leisureman will probably demand a vast Disneyland, a limitless Expo '67, and there would be worse things than bashing bongo drums in an LSD haze and smelling flowers. Before I finish let us remind ourselves that the hippies are not 14 and 15. They are adults, who try to reject the shaping lessons of disappointment, and who make an ideological unit of the omnipotentiality of adolescence and realism.

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Panel Discussion: Do Adolescents Need Separate Treatment Facilities?

Chairman: W. J. Hendrickson, MD
Panelists: G. J. Sarwer-Foner, MD; H. Caplan, MD; H. E. Lehmann, MD; S. J. Shamsie, MD.

Chairman: *Dr. W. J. Hendrickson:* Any constructive consideration of the question of "Do Adolescents Need Separate Facilities?" requires first that we clarify just what is meant by "separate treatment facilities." By this do we mean, as I believe is the case here, that the patients be housed in separate hospital ward facilities devoted exclusively to teenage patients? Or, by "facilities" do we have in mind separate divisions for activity programs, such as school, devoted exclusively to adolescents, wherever they may be housed? Or, do we have reference not so much to physical facilities, as to the fact that the teenage patients be treated by a group of psychiatrists, nurses, occupational therapists, psychologists, or other professionals, and devote themselves especially to working out better approaches to adolescent patients–in recognition of the fact that these approaches may be somewhat in contrast to those which are commonly used say with younger children or with adults?

Obviously, the answers which we may or should give to our question will vary enormously depending on which of these or other possible interpretations may be given to the expression "separate facilities."

I am now pleased to introduce our first speaker who is Dr. Gerald J. Sarwer-Foner, Associate Professor of Psychiatry at McGill University, and Director of Psychiatry at the Queen Elizabeth Hospital in Montreal.

Dr. Sarwer-Foner: Thank you, Mr. Chairman. In any discussion of treatment facilities for adolescents, the philosophy of treatment as a whole must be considered. I am going to make these comments as an introductory statement and will elaborate on other aspects of this problem when my turn comes around again.

It is a well-known fact that society influences all who are in its social field of force. I have elsewhere pointed out the tendency, in our present society towards greater specialization and narrower "professionalism", that pervades our present culture. ("Some Comments on Rehabilitation, the Family Unit and Society", J. Nerv. Ment. Dis., 136:422 (May) 1963, and "Psychotherapy in Relation to the Changing Canadian Scene". Canad. Psychiat. A. J. 10:98 (April 1965).

Is medicine further to be compartmentalized, so that simpler and narrower skills are farmed out to different people? Are you, for example, going to teach nurses to do simple suturing, etc. To extend this analogy to psychiatry, are you to compartmentalize it into a series of sub-specialities, dealing with different stages of life? If so, then an apriori social case for a separate speciality to be called adolescent psychiatry has been made, and thus for separate treatment facilities for this new speciality. If not, and I am one who believes that it should not be done, then we should not separate the adolescent stage from the rest of life. Exposure to this phase should be a normal part of all medical, and particularly of psychiatric teaching and experience. The reason for this in my opinion is simple that adolescence is a fundamental phase through which all people have to pass to become adults. It is par excellence the phase in which all children become partial adults. The working-through of their problems in becoming adults should be part of the training of every physician and of every psychiatrist. It should therefore not be a specialized field.

Saying this, should not be construed as meaning that I am opposed to people having a special interest in this area, or to their doing particular work in this field, for this is a very different thing. An individual degree of expertise is quite permissible. The formation of a separate sub-specialty is something quite different.

In short, all physicians, and in particular all psychiatrists, must receive a thorough training and grounding in adolescence as a normal life stage, and in the particular problems of treating adolescent disturbances and diseases. The greater expertise of doctors who devote much of their time to this should be used in such teaching, treatment and in research. The field as a whole should not become a narrow speciality.

The second point is about the treatment facilities. It is self-evident that the adolescent in any one culture, or society, reflects the problems within that society as a whole; and particularly the problems that society may have in allowing young people to take on the full adult role. To this is added the individual constellation of problems a particular person may have. As an example, in our present culture, young people are being kept under tutelage for longer periods of time and therefore have a socially prolonged adolescence. In the face of this you have a certain sort of social problem reflecting the revolt of some against this prolonged tutelage. In addition to this we are increasingly a hedonistic society in which pleasure seeking, or the attainment of any kind of pleasurable moment with excitation, is the goal and is becoming accepted as a way of life. Many of our adolescents will reflect problems in these areas, and the result is that treatment facilities have to be designed which reflect these social concerns. Many of ours in fact already do.

Another aspect of this is, who is to do the treatment, and what kind of person is he to be. The physician treating adolescents must be a mature person and must in his adult maturity present a suitable object with whom the adolescent can identify. In this sense he must be a "good object" for the adolescent in his search for stability in becoming an adult in a particular culture. Such doctors must have a strong sense of personal identity and values of their own. They must be prepared to deal tolerantly, sympathetically and firmly with the problems of the adolescent who may be in doubt about social values or may have serious identificational difficulties.

In this context, when the question of separrate treatment facility arises, we must ask separate treatment facilities for which problems? For are we talking about disturbed behaviour or anti-social behaviour; are we talking about behavioural expression of psychotic states or borderline states; or are we considering facilities for those mentally retarded or irresponsible; are we discussing neurotic disorders, depressive disorders; or are we really considering what I call the "impulse-ridden character disorders." For all the above reactions are seen in adolescence as in all other phases of life.

Here I am briefly discussing the criteria that fit some patients for treatment in facilities which have the same standards as to health and disease as the larger community. Such patients can thus be treated in general hospital psychiatric units, outpatient clinics, etc. Others may need very special treatment facilities, such as different mental hospitals which may or may not have, very special criteria for admission and discharge.

For me the basic issue is that treatment facilities for adolescents should be those which encourage progressive maturation from adolescence into adulthood. This must include the possibility of learning, and identifying with, adult ego ideals, adult responsibilities and adult goals, whatever these may be, in a particular society. The aim is to have them mature into responsible adult members of a particular society, into individuals who incorporate into their ego the ego ideals of their family and of society as a whole.

A word about the problems posed by social conformity and personal moral values.

The treating physician, although he must be a solid, sympathetic, firm and skillful person with a strong personal ego, and good, or at the very worst adequate, personal ego ideals, must never impose his moral values onto the patient. Of behaviourally non-conformist adolescent patients, the odd one will show true creativity and genuine originality along with a fair level of eccentricity. Such a person will identify with the above mentioned type of physician to expand their own contact with reality and to progressively develop their own capacity to function successfully. The keynote to be used in the therapeutic situation to measure the originality of such a patient is the capacity of the patient to test reality adequately, that is to say, to see the consequences of their position and behaviour, and to visualize as well, the way others see them and respond to them–all within the framework of an integrated series of attempts to achieve personal life goals.

The majority of behaviourally eccentric adolescents is not really original or genuinely creative, but are followers, seeking identification with a sub-group of have-nots as part of their own search for a personal identity. The brief description of the kind of physician, already given above, applies equally to the successful treatment of such patients as to that small minority who are genuinely creative.

For such tasks I believe that separate treatment facilities for adolescents (i.e. treatment facilities in which adolescents are separated as a special group and treated as such) are wrong and unnecessary. I am against segregating them in special groups and so-called adolescent units in general hospital settings. This does not mean that I am against special facilities in particular hospitals, such as a mental hospital, for particular problems. There I think a case can be made for special facilities for particular situations, such as for the impulse-ridden character disorders. Furthermore in all hospital units, there is a need for special educational work and leisure activity programmes. I will say much more about this later, but the above is meant as introductory orienting remarks.

Dr. Hendrickson: Thank you, Dr. Sarwer-Foner, I think we will go ahead with our other speakers and save the discussion until after each speaker has made an introductory comment. The next speaker is Dr. Hyman Caplan, who is Director of Child Psychiatry at the Montreal Children's Hospital and Associate Professor of Psychiatry at McGill University.

Dr. Hyman Caplan: Those questions which stubbornly defy an answer often turn out to be the wrong questions. I believe we have such an example before us in this panel: "Do Adolescents Need Separate Treatment Facilities?" Let me state the following in a summary form and detail further remarks later.

1. Adolescents normally have a wide range of varying, shifting, oscillating, alternating behaviour patterns.

2. Adolescents requiring treatment show even more variations in how they present

their problems and how they defend themselves against these problems, even though the core of what they are struggling with remains relatively constant, namely, the omnipotentiality which reveals their inability to accept an increasing commitment to life and reality, a commitment which is the hallmark of the passage from youth to adulthood.

3. We cannot lump all adolescents together. Most adolescents could and should be treated outside of special facilities–if by "facilities" one means buildings, hospitals, or especially designed architectural structures. For those who require "caretaking" away from home or for those who have no homes and whose problems have forced society to provide "holding" situations, there is a range of possibilities. In the hospital there are open and closed wards, wards for children, adolescents and adults. There are also group foster homes, special schools and larger and smaller institutions. May I now reformulate the question: Do Adolescents presenting a wide spectrum of pathology, symptomatology and identity crises require therapists with special skills and attributes of personality? Here I can give an unequivocal answer "YES". What is most urgently needed is mature clinical judgement; when to hospitalize and for how long; when not to hospitalize; when to move the adolescent out of a locked, constricting, controlling and therapeutically supporting environment in which, for instance "acting out" must be contained; and where, for example, "running away" has valuable components, so that the "facility" or, more accurately, the staff in the facility accept it for what it may be. I suggest that "running away" is at times an opportunity for the adolescent to become aware that he is hoping for something, that he is trying to find something quite elusive. If the disturbed adolescent finds out that his search is in vain, that the manner in which he is going about it is ineffective, and the urgency of finding it immediately cannot be gratified–and all these frustrations cannot be projected on to the treatment team–then he has profited significantly from such an experience.

Pumpian-Midlin points out that the resolution of omnipotentiality in the normal healthy youth comes about from "the acting out" of omnipotential fantasies in reality and submitting them to repeated reality testing. I believe the separate or special facility needed is the interpersonal skill and sensitivity which take into constant account that even the psychotic adolescent is not psychotic at all the time and that as the clinical picture changes so must the intervening therapeutic modality. There may be need for a rapid move from one setting to another .Discharge from hospital with subsequent readmission is not necessarily a sign of failure, but at times very much part of a necessary resonance within the therapist of the adolescent's requirements for experience in further growth and development. It is exactly this continuous testing of reality which appears so bizarre and is so disquieting to the adult who has already committed himself. The therapist struggles not only with the rapid shift in emotional positions in the adolescent, but with the countertransference aspects of his own inadequately resolved omnipotential strivings which may be activated by his youthful patient.

I believe that the psychiatrist dealing with adolescents requires the following skills and attributes:

1. He should have experience with the earlier phases of growth and development, i.e., the wider range of child psychiatric disorders.

2. He should have adequate experience in dealing with adult personality disorders and particularly in the handling of parents in brief, crisis-oriented guidance or therapy. Such parents should be accepted in the role in which they present themselves, not quite as informants bringing data, not yet as patients, but as individuals involved with their adolescents in complex interpersonal relationships.

3. He should have experience in family group therapy and be sensitive as to when to use it and when not to use it (the latter is the more difficult).

4. He should be able to work sensitively with the adolescent on a one-to-one basis. He should also provide leadership to larger based teams of paramedical professionals, organizing a meaningful therapeutic milieu, not only within the hospital setting, but equally in the school and community, i.e., the natural habitat for rehabilitation.

5. He should have the ability to move from active to passive roles, from talking a lot to listening a lot, from decisiveness and firmness to tolerance and understanding, and, at times, a readiness to risk a setback for the adolescent who may thereby learn how to cope with life's hazards himself.

6. He should know that before you can treat someone you must have a patient to treat. This means primary attention to consolidating a therapeutic alliance or manipulating the environment and moulding the milieu in which the patient is repeatedly confronted with his denial mechanisms so that he can accept the fact that he needs help and begins to welcome it. The ability to empathize does not mean a complete identification with the adolescent. Empathy here means only a temporary and partial giving up of one's identity for the benefit of reaching the patient.

And so I come back to my thesis that the need for "separate facilities" is fundamentally the need for "special personnel" with particular experiences and skills. The cardinal priority is for the use of "the self" as the vehicle for either a "one-to-one" individual therapy relationship or as leader or member of a team of experts carrying out a specially designed milieu activity as part of an overall programme of treatment.

Dr. Hendrickson: Thank you, Dr. Caplan. After a brief advance preview of what some of the speakers are going to say, I was anticipating all sorts of controversy. I must say it's hard to quarrel too much with most of the comments that both Dr. Sarwer-Foner and Dr. Caplan have said so far. I think we must continue with our other presentations. The next speaker will be Dr. H. Lehmann, who is the Clinical Director here at Douglas Hospital and Professor of Psychiatry at McGill.

Dr. Lehmann: Mr. Chairman, ladies and gentlemen. Do adolescents need separate facilities? Well, in fact some have those separate treatment facilities. We have a separate Adolescent Unit at Douglas Hospital, and the question then really is should such separate facilities continue to exist and perhaps should they increase or should we abolish them? This question points to another question: should there be segregation or desegregation of the adolescents? The adolescents themselves certainly want segregation–they want to be very separate. Should we aid and abet them in this or should we help them to desegregate? On what is segregation based? Segregation is based if it exists on differences and these differences may be of three different kinds. Differences that one might respect, differences that one might emphasize and then there are differences that one might, and should disregard. An example of the differences one might respect is the difference of the sexes, male and female; after all we have male and female patients sleep in different rooms, although we might not otherwise separate patients on the ward. Differences that should be emphasized would be therapeutic needs and clinical requirements; for instance, children and geriatric patients should probably not be treated in the same facility as adults who are not geriatric and not children, because both children and geriatric patients are out of the stream of life while adults and adolescents are within the stream of life. Perhaps the existence of special therapeutic programmes, or acceptable versus unacceptable behaviour may also be considered reasons which would justify segregation. And finally, one should disregard segregation based on differences as socio-economic differences. Well, if we apply these considerations to adolescents–should they be segregated or not, and if not, where should they be–with children or with adults.

What is an adolescent? Well we have heard all day very enjoyable accounts of what adolescents are, let me add just one other definition: an adolescent is a person in transition from childhood to adulthood. My personal view is that adolescence is the only time when everyone has a chance to be imaginative, creative, dedicated, idealistic and enthusiastic. This is also the peak time of physical and intellectual strength. Nobody has a higher I.Q. in his whole life than when he is an adolescent, nobody has ever more physical powers than when he is an adolescent. Adolescence is a time when dependency ceases, because of endogenous changes, because of exposure to pressures from his peer groups, because of expectations by his elders. The adolescent is supposed to make a living, he is supposed to choose an occupation, to accept responsibilities, but most of all, the adolescent becomes independent because he has tremendously expanded ideas and because great new powers are emerging within him and not the least of those is an ability to think abstractly, to think in ideal terms, in conceptual terms. Nobody can think abstractly until he is about twelve or thirteen, and that is a tremendous new horizon that opens then to a human being.

All this, then, ushers the adolescent into independence. He is often in opposition to the real world, simply because he is idealistic and for that reason is independent too. There is one thing the adolescent lacks–he has everything the adult has and actually in many ways has much more than the adult has–but there is one thing he lacks and that is experience. Experience can only be acquired through learning, through exposure to life situations, and in this way one can work out ones own life philosophy and ones own solutions. But it takes time to get experience and the adolescent is impatient. He becomes impulsive, because of the tremendous pressure of these new emerging powers. He becomes a problem in adolescent turmoil because he is impatient and impulsive, because he cannot apply experience. But his break from childhood is complete. The adolescent is not a child who has lost his appealing charm and cuteness, but he is a young adult who lacks experience, patience, knowledge of his limitations. Now, if that is so, why not treat him together with the adults? He may need special therapeutic and educational programmes–very definitely he will–but so do many others within our adult treatment services. Some people might need individual psychotherapy, others may need group psychotherapy, still others might need occupational and recreational therapy; so the adolescent will need particular facilities for educational and therapeutic programmes. He needs perhaps a special space where he can indulge in his noisy and vigorous activities which may otherwise annoy the others. But there again we can have a special room or two where adolescents can congregate for their recreational activity. Most of all, the adolescents need more patience and tolerance then we usually have and here I vigorously endorse Dr. Caplan's point that what matters is really the psychiatric staff, nursing and medical staff. Perhaps we need a higher staff-patient ratio for the adolescent, but not because they present special problems, but simply because they are somewhat more difficult adults than the not-so-adolescent adult. In my opinion adolescents do not need a special building, they might need a special administration, but they do not need entirely separate facilities. In fact, since the adolescent can understand the adult's language and can speak it if he chooses to, although often adults cannot understand the adolescent's language, why should we not treat them with the adults, since in the end they have to learn from experience and from exposure to the adult world? If you put a lot of adolescents together, a tremendous pressure is generated, like in an atomic pile, and all kinds of chain reactions develop. I would think that if you dilute this pressure by having one or two adolescents with three, or four, or five adults, this would help. The adults would have the same effect as a graphite rod in an atomic pile –they would slow down the reactions and prevent a chain reaction from occurring. For these various reasons, then, I would think that it is not necessary for adolescents to have special treatment facilities, in fact, I would think it advisable for them to be treated together with adults.

Dr. Hendrickson: Dr. Lehmann's comment about the adolescent being a young adult who differs from other adults and the lack of experience reminds me of a story. Some very high priced consultant was advising some people about I believe an architectural problem and somebody on the committee asked him, "What is it anyway that we're paying you five hundred dollars a day for?" His reply was "that is for my good judgement." Well the man thought for awhile, then asked "how did you get such good judgement?" "Well that comes from experience." "Well where does that experience come from?" "Well that comes from making bad judgements."

To get on with our next speaker, who is already well known to you, Dr. Shamsie, who as you know is Director of the Adolescent Services here at Douglas Hospital and to whom we are indebted for the organization of this meeting.

Dr. Shamsie: Mr. Chairman, I think that the time has come for some plain talk, that is what I intend to do. What I have heard here is absolutely opposite to what has actually been happening on the scene in Montreal and I am sure in other places. To take the situation in Montreal as an example, the development of the Adolescent Unit at Douglas Hospital was the result of frustrations in getting a difficult adolescent admitted to children's or adults' wards. At that time when the decision was taken there were no psychiatrists in Montreal who were mainly or exclusively dealing with adolescents. The pressure came from both adult psychiatrists and child psychiatrists who wanted to get these difficult patients out of their hair. At that time there was no discussion on the philosophy of treatment of adolescents, there was only one purpose, that to provide a segregated place for difficult teenagers who neither could stay at home because of their acting out behaviour nor were acceptable in adult or children's wards. Mr. Chairman, this is the history of the development of adolescent unit at Douglas Hospital. From my visits to the adolescent units in U.S. and U.K., I can say that the history of other adolescent units is very similar, there development was due to the pressure of child and adult psychiatrists who did not want these difficult teenagers on their wards.

At this meeting, however, we have the opportunity to discuss the future development of facilities for the ever-increasing number of adolescents who are being referred for admission to hospitals. I agree that adequate staff with proper training and experience is the primary need, but I also suggest that the experience gained in managing and treating a six-year old or twenty-six year old is not necessarily applicable in treating a sixteen-year old. This experience can be gained by actually working with this age group. The problems which an adolescent faces are due to some unique developments which take place during this period of life, and conflicts which arise for him and his family are not the same as in childhood or in adult life.

I do not suggest, Mr. Chairman, that every individual who happens to fall within this age group, must necessarily be treated in a separate adolescent unit, however, there is a group of adolescents, whose aggressive and difficult behaviour makes it difficult to accommodate in children's or adults' ward. This is borne out by the number of adolescents who are being referred to us from the Montreal Children's Hospital and also from the adult wards of Douglas Hospital.

Dr. Hendrickson: Thank you, Dr. Shamsie. In other words, you are suggesting that no one but a professional committed to the treatment of adolescents would put up with them. I think Dr. Caplan is anxious to be first to comment on what Dr. Shamsie has said.

Dr. Caplan: I have been wondering why Dr. Shamsie placed himself last on the panel. I see now that it was to needle us into a more animated discussion. I have not disagreed with the need for special separate facilities for selected adolescent patients. Neither have I indicated anywhere in my talk that adolescents requiring hospitalization should be hospitalized in a children's unit. I disagree with Drs. Sarwer-Foner and Lehmann that adolescents necessarily belong in an adult unit. What is most needed is a range of facilities and the clinical judgement to be able to select what is indicated at any given time. It may be true that separate adolescent facilities have developed throughout the country because of the urgent pressures placed upon community mental health resources. But is it logical that pressures exerted by patients should railroad professional people into creating adolescent facilities, or should the careful planning of a network of treatment programs be the result of the efforts and cooperation of competent experienced well trained psychiatrists?

I would suggest that if the professional personnel involved in child, adult, family and community mental health centres could get to the problems earlier, work with these cases more energetically, consistently and skilfully for longer periods of time, then the existing "separate" in-patient facilities for adolescents, although still necessary, might be utilized for different goals and objectives. At this time the need in our community for therapeutic services, individual, family and community oriented, is so great that additional budgets could easily be absorbed in any or all existing child, adolescent, family and adult programmes. There is a beginning spectrum of good facilities in this community; what we need is greater awareness and recognition of the contributions of others and cooperation and integration among those responsible for mental health planning and care. Mental illness always tends to produce "splitting" within the psyche of the individual, within the family unit, and we can also see it in the community at large. We should resist it in our mental health diagnostic and treatement programmes.

Dr. G. J. Sarwer-Foner: In my preliminary statement I pointed out that society imposes certain tasks on its public hospitals. It may also impose certain limits on private hospitals (e.g. the time limits as to how long one can keep patients in a general hospital psychiatric units, which are designed for treatment of acute conditions, or for exacerbations of subacute or chronic conditions). Now, I agree completely with what Dr. H. Caplan has to say about the need for empathetic, skillful and well trained staff. It should be stressed that the best way to obtain a very well trained staff is to expose them to the maximal psychiatric experience, and not have isolated units, one to treat the middle-aged, one for the aged, still a third for adult life, a fourth for menopausal women and a separate one for adolescents, or for middle-aged men with the seven- or ten-year itch. Rather it should be stressed that all these stages of life represent age groups at which life crises can arise. All psychiatrists should be trained to handle these.

If we discuss therapy, then for individual therapy the skills and sensitivity so well described by Dr. Caplan are needed. If we are discussing hospitalization and the treatment offered there, then the criteria for admission to the general hospital psychiatric unit are the same as those criteria, for illness and health, for admission and discharge; held by the community as a whole, and the adolescent patient who is to be admitted to such a unit must fit the criteria for admissibility.

The general hospital psychiatric unit can offer relatively short-term hospitalized treatment for acute psychiatric breakdown. It can perform ego patching tasks, restoring a patient to relative social recovery rather quickly; it can offer continuing ongoing care in an outpatient programme, and preventative care in extramural programmes; but, by definition of its sociological structure as an acute treatment facility; it cannot treat by hospitalization long-standing character deformation, or certain character neuroses needing extremely long term therapy. It is truism that the average general hospital psychiatric unit is not a good place in which to treat what I have called the "impulse-ridden character disorder."

By the term "impulse-ridden character disorder" I mean those patients who seek immediate gratification or discharge of their sexual or aggressive drives and needs, and have so little control over these impulses that even modest stimulation of these drives causes them to lose partial or complete control over them, resulting in immediate and inappropriate pleasure seeking or apparently irresponsible behaviour.

Now adolescents with these conflicts are no better treated in short-term hospitalization, in general hospital psychiatric units, than are adults with such difficulties. Neither are well handled in such settings. The patients who impulsively put a fist through a window, fire a shot at themselves, or at the ceiling, drive a car off the highway at high speed, or impulsively strike a police officer, etc., are all poorly controlled by a short-term hospitalization, when such behaviour is part of their usual way of doing things, i.e. of their character structure. The only difference between such adolescents and adults lies in the fact that adolescents are in a transition period, and in some, in whom this pattern is not yet definitely fixed it can change into a more stable one. The ones who do not change, but remain impulse-ridden with poor control, become our adult impulse-ridden character disorders. These are relatively small in number, and are less frequently seen in general hospital psychiatric units, but they are much more frequently seen in prisons and state mental hospitals.

Adolescents with behavioural expression of innner conflicts or to use the common term who "act out" (a term which I dislike as having been borrowed in an improper way from psychoanalysis) are often the ones who are brought to medical attention rapidly, either by their parents or by the school or court authorities. Thus the problem of dealing with, several-to-many such patients at any one point of time, arises in general hospital units. Here the most explosive hospital milieu situation is created when these are isolated in a separate adolescent unit, at least in a general hospital setting. On the other hand, distributing such patients among the random group of adult patients tends to offer a better social framework for dealing with the behavioural expression of such patients' inner conflicts. This is a potent and cogent argument against separate adolescent treatment facilities in a general hospital setting. All that Dr. Caplan has already said about a sympathetic, and well trained staff, that can adapt to any role called for by reality, applies here. The need for an appropriate group activity, educational and leisure programmes for adolescents is clear; but even here, participation of adult patients in at least the leisure time activity and in group programmes, is a very beneficial thing, in a general hospital setting, in toning down what can otherwise become explosive social behaviour, in which one sets fire and provokes and stimulates aggressive or destructive behaviour in the other.

Dr. Shamsie has also mentioned the fact that society imposes the treatment of impulse-ridden, and other very difficult patients in the adolescent age group onto the mental hospital. It is in the context of needing a facility for long-term and very long-term treatment of such patients in a mental hospital setting, that an excellent case can be made for a special adolescent treatment facility at least as to therapeutic, educational and leisure time programmes, and often in terms of daily living and total milieu as well. The tolerance of such a unit in a mental hospital setting for disturbed behaviour and for impulsive behavioural expression of inner conflicts is usually much greater than that of a general hospital psychiatric unit.

The basic therapeutic problem remains the same, it is to help the adolescent progressively identify with solid, sympathetic, firm people, who are realistically "good objects" and thus help the adolescent evolve towards his own ego ideal, and as a result progress towards better health. The empathy, the skills, the close attention to external reality, the need for excellent control of the milieu, many of the factors already discussed by Dr. Caplan are needed here. It is these skills and the necessary experience to acquire these skills, that we must teach by exposing our residents and other members of the professional team who work with such patients.

Dr. Hendrickson: If I appeared to rush you from the platform, Dr. Sarwer-Foner, it is in the interest of giving someone else the chance to speak, namely the Chairman. I will allow myself a few moments to answer. First of all on two occasions, Dr. Sarwer-Foner, you have deplored the alleged tendency to seek to establish "adolescent psychiatry" as a separate speciality and I don't think that anybody here has stated this. I have been hobnobbing with professional "adolescent psychiatrists" for a long time and I don't know any of us who are interested in this. I have been deploring over specialization in medicine and certainly in psychiatry, and I submit that your fears in this regard are groundless. One other comment I will make, and I think some of the observed clinical facts support it, is this: That not only with inpatient treatment of adolescents, but also with their outpatient treatment it has been my observation that most psychiatrists, be they child psychiatrists or adult psychiatrists, avoid like the plague seeing adolescent patients in treatment. And if they do see them, often do so to the everlasting regret of the psychiatrist and the patient, because these youngsters are generally handled very badly by most psychiatrists. I think all panel members have recognized and Dr. Caplan and Dr. Shamsie have brought out especially, that the people who work with teenagers should have special qualities and experience. So, whatever is required for successful psychiatric work with teenagers–be it time, inborn talent, special training, or more-than-average masochism–not all psychiatrists have it, nor do they want it!

The Chairman will now give the floor back to any member of the panel who has a comment.

Dr. Shamsie: If I understand rightly, Dr. Sarwer-Foner has stated that impulse disorders in adults are not well treated in a psychiatric ward and therefore the same problem applies to adolescents. My answer is that impulsivity is not as common in adults as it is in adolescents. When an adolescent is depressed he acts out, when he is isolated, he acts out, when he is rejected he acts out, and acts out in an impulsive way. Therefore, the number of adolescents who are impulsive and acting out are far greater than one finds in the adult population.

Dr. Hendrickson: We will call on Dr. Lehmann now for a brief comment. Then I think we are going to have to interrupt our fighting among ourselves to let the audience join in the fun.

Dr. Lehmann: I did not offer to take part in this debate, but Dr. Shamsie invited me, and when I hesitated to accept he urged me, and now I think I am involved. I just cannot see where this argument will lead us. Dr. Shamsie says that no other hospital will keep adolescents, they will always refer them to the adolescent unit, when they become too difficult. Well, when they become too difficult at the Adolescent Unit here in Douglas Hospital they are sent to the Adult Unit! These are facts. The facts are also that the Adolescent Unit has raided our best psychiatric staff. They are all concentrated there, and if we could have the high staff-patient ratio they have, and if we could have all these excellent people they have we could do a good deal better in an Adult Unit and we could take care of many adolescents that they now have all in one spot. We would have them all distributed over a much larger area and probably there would be much less acting out. Acting out is contagious and if you have a great number of acting out people together a greater pressure is generated than if you distribute them. I do not say that the adolescent units we have are not functioning well under the circumstances, but our question was: should we have them? I think we should not have them. I think we should have a much better staff, for all psychiatric units and not only for the adolescent unit. And I am against concentrating all adolescents in one or two places.

Dr. Hendrickson: I agree with Dr. Lehmann, something which I am feeling most uncomfortable about. In our Adolescent Unit we are working with a relatively small number of adolescents, the Unit is richly staffed and have more or less a selective admission policy. Throughout Canada, United States and in Europe there are hundreds of adolescents, those who are the sickest, whom we stick in state hospitals, and who are receiving relatively little attention. As with adults and children, a small number of adolescents who are relatively healthy are getting most of our psychiatric attention, which is nightmarish. We, as citizens, and doctors, I think are going to have to come up with better answers for the solution of this problem which should not be allowed to continue.

I wonder if at this point we can entertain comment and questions from members of the audience.

Dr. Rakoff: I was very alarmed by Dr. Shamsie's reduction of adolescent care. He has suggested that only serious behaviour problems qualify for an adolescent unit. An adolescent unit should be a place for research and training. To limit oneself to treating serious behaviour disorders in such a setting is to make an inadequate use of such a facility. It is also known that the success in treating such disorders is somewhat rare. I sincerely hope this is not what Dr. Shamsie meant.

Dr. Hendrickson: Can we safely assume that this is not all Dr. Shamsie said?

Dr. G. Sarwer-Foner: I think there may have been some confusion in the minds of some as to what I tried to say about the character disorders as seen in adults and adolescents.

One has to distinguish between (A) "Acting out" behaviour in an adolescent, which is not due to a fixed character structure, but is due to an incompletely developed ego, incomplete ego defenses and temporarily weakened ego controls. Such behavioural expressions of inner conflicts can be treated in short-term hospitalization such as in a general hospital psychiatric unit, with appropriate follow-up therapy when necessary. (B) On the other hand in those adolescents, which I think the state mental hospital adolescent units receive in large numbers, where there is an undeveloped capacity, or an only poorly developed capacity to control impulses, where the patients respond to the impulse of the moment, such cases are not suitable for any short-term facility. These patients, if not treated over long term, and even very long term, in a setting which helps them develop progressive maturation of their character structure and ego defenses end up as the adult impulse-ridden character disorder so often seen in prison and in other social difficulties.

The short-term cases can be treated, if in not too large numbers, if not lumped together where they stimulate each other, in general hospital psychiatric units. Those who need long-term and remedial character treatment must have a long-term facility, in which the entire milieu can be better controlled over long periods of time.

Dr. Roger: What about the qualification of non-professionals working with adolescent inpatients, and their selection and training?

Dr. H. Caplan: This question gives me the opportunity to develop my theme further. It appears that thus far the discussion by many of the panelists has focused too much on the treatment of the adolescent through hospitalization. Statistically, this is only a fragment of the problem. Moreover, the need to hospitalize the adolescent in a crisis may, and often does, reflect the failure of past attempts to deal with such cases. These failures may be the result of insufficient efforts to assess and treat potential trouble earlier in childhood.

There is a lot that is known and well documented in the literature that pertains to methods of case-finding, individual and family group therapy, the role of social, welfare and group work agencies; and the role of the school. The school, in particular, has an unusual opportunity to make a significant contribution to a captive population five hours a day, five days a week. One of the chief responsibilities of the specialist in child and adolescent psychiatry is to develop those skills which will enable him to serve as a psychiatric consultant to the paramedical disciplines of social work, nursing, teaching and so on. This sort of consultation means basically staff-development over the immediate needs of various professionals around their own case material, using skills which they already have but putting them to better advantage.

I work in a good-sized paediatric hospital. In the last few years I have found it most rewarding to work very closely with paediatricians who see a great many more adolescents than psychiatrists do and who are in a position to do a great deal of primary prevention. The profit which the paediatricians may derive from increased awareness of mental health principles is of crucial importance as they are in the front line of detecting the earlier signs of mental illness. They can spot the high-risk pre-school child; assess the earlier high-risk constitutional and environmental factors; tag the high-risk developmental deviation, and take note of high-risk experiences, such as separation from parents, etc.

We have been talking about the need for more beds for adolescents at the Douglas Hospital. Even if we had ten times as many beds as we have now, we would be struggling desperately with numbers unless we could use all our mental health workers more effectively. We must pay more "budget" attention and give "staff development" time to the many existing disciplines who work in the "helping" professions, and perhaps we should create new ones. The challenge in the field of mental health is changing rapidly; so are the patients who come and don't come for help; and so, too, are the skills and needs of professionals who try to help. Again I repeat; as important, as setting up beds for adolescents and as separate institutional facilities, is the need for special selection and training of personnel for two main purposes:

1. To staff "special" residential facilities for adolescents.

2. To deal with the much larger numbers of disturbed children adolescents and their families, by using better trained mental health workers. The proper deployment of these professionals–in the community, the neighbourhood, the school, as well as in the outpatient psychiatric clinic may well forestall the need for hospitalization.

Dr. Hendrickson: I trust, we are all using this term "adolescent psychiatry" in quotes as it should be, since "adolescent psychiatry" is not a recognized speciality, nor should it be, although I 've been accused of trying to make it so. When we opened our Adolescent Ward in 1956, we decided that we would preferrably take middle-aged nurses. But we found none, and started with a talented head-nurse and other nurses just out of nursing school. And over the years, we have had until very recently only one application from a middle-aged nurse, who was so grossly and obviously psychotic we couldn't use her! This reminds me of a story of a doctor in Texas, who was starting a medical adolescent ward, and got the opinions of the teenage kids in the hospital about the staffing and programming they should have. The kids were asked how old the nurses should be. "Middle-aged" was the answer. The doctor fortunately had the presence of mind to ask one other question: "About how old is middle aged?" "Oh, about 22 years of age." So, we have been hiring middle-aged nurses of about 22 years of age.

Dr. Shamsie: I would just like to make a comment on what Dr. Caplan said that I totally agree with him that fifty beds in any hospital will not provide the answer. In recognition of that we have been working very closely with the Juvenile Court and the correctional institutions in our community.

Dr. Hendrickson: The question from the floor is what are the diagnostic criteria for making the judgement that this or that adolescent should be admitted and treated in one kind or another of inpatient facilities, such as an adolescent ward, adult ward and so on. Would some member of the panel like to comment on that? Dr. Lehmann, if you would.

Dr. Lehmann: My answer would be very simply that I am not so certain that there are any adolescents who should be treated in a group, in fact I am very much of the opinion that disturbed adolescents would be much better off if they were not sleeping together and spending most of their time together. They should have an educational and recreational programme together, but otherwise they should be separated. So for that reason the question simply would not apply to me. I would have to get the evidence first that any kind of adolescent group should be placed together.

Dr. Hendrickson: I might comment on the basis of our own experience. Since 1956 we have been in the fortunate position of having an all-adolescent ward, and at the same time are able to treat some of our adolescents by choice in a closed adult ward, which is also generously staffed. They sleep in an adult ward, but have a whole day's activity programme, including full-time accredited school, specially designed for them. They are seen daily, or as often as needed by our residents under our supervision. Many of the very sick adolescents we admit may spend the first few months in the closed adult ward. On the basis of my own experience there does not seem to be much doubt in my mind, at least in our present state of knowledge, that some adolescents are better treated in adult wards, some treated better in an all-adolescent ward. In fact, unquestionably some adolescents do better, in the more competitive, stimulating society that exists in an all-adolescent ward.

Few hospitals (none that I know of) have had the opportunity we have had to learn the special advantages and disadvantages of treating adolescents in adult wards where one has almost ideal conditions, of staffing facilities and programme for their care–combined with a comparable opportunity to observe the advantages and limitations of treatment in an all-adolescent ward. Roughly speaking the "sicker" adolescents in all diagnostic categories, the more grossly psychotic, the more uncontrolled delinquent adolescents do better in an adult environment. We receive referrals from all over the State of Michigan, mainly with hopes for admission. Many of these adolescents are sicker than we think we can treat and have to be referred for commitment to a State Hospital.

Dr. G. Sarwer-Foner: Our Chairman's comments show very neatly how society imposes certain tasks upon one hospital and certain tasks on others. I think he gave a very nice description of this, as has Dr. Shamsie, Dr. Lehmann and Dr. Caplan. Thus it is clear that all of us have different therapeutic facilities and are treating our own small pieces of a total pie. The particular piece that we are dealing with is sociological artifact, in the sense that society imposes or helps us build a structure that deals with one or other aspect of the total problem.

In a general hospital psychiatric units, I would say that those adolescents, who through shyness, through lack of development of social skills, or with poor interpersonal relationships, gauche dating behaviour, conflictual problems with their peer groups, presenting such problems can benefit from some aspects of group therapy, group contact and group recreation facilities. Here there is a real place in every facility, including those of a general hospital psychiatric unit, for grouping adolescents as well as adults in such group activities, leisure time and recreational programmes, which help deal with the socialization, fraternization, and the development of such abilities. In contradistinction to this, disturbed adolescents who behaviourally express their conflicts, should be well diluted and not constituted as a group.

Dr. Hendrickson: Unless someone on the panel is itching to make a comment, I will now call on Dr. Henry Durost, who is Executive Director of Douglas Hospital, to sum up our proceedings. Dr. Durost.

Dr. Durost: Thank you very much, Dr. Hendrickson. I have not really defined my task as one of summing up the proceedings, for a variety of reasons, one of the more important being that I have missed fifty percent of the proceedings due to other activities. I would like to make the comment that Dr. Hendrickson apparently has a very active brand of catnip or some other substance which produced a very stimulating response in the members of the panel. Generally speaking, panelists tend to be polite to one another and any points that they may differ on they save for after the conference. These discussions don't very often reveal true feelings quite as openly as the panelists and some of the audience have done today and I would like to congratulate all of them on having done so.

It has made a very stimulating and invigorating end to what I believe has been a highly successful day. I would confine my own remarks to some expressions of appreciation. I would first like to say that Douglas Hospital is extremely happy to have had the privilege of having this conference on Adolescent Psychiatry here. The attendance has been remarkably good. I would like to thank all the speakers who have done an excellent job. What I have been able to participate in I have enjoyed immensely myself as I am sure you all have. So I thank you, particularly Dr. Jenkins, Dr. Hendrickson, our guests from the United States, but also all of the panel members. Their presence has contributed greatly to the success of this meeting.

I would on behalf of all of you, like to express to Dr. Shamsie, to his Committee and to the large number of people who have been involved in planning this conference the thanks of each of us here. They have done an excellent job. The interest in Adolescent Psychiatry is clearly a burgeoning one, and the timing of this meeting has been excellent. Thank you all very much for coming.

Chairman's Summary Comment

To the printed record of the actual proceedings of this panel, I wish to add some remarks which are in essence those which I had planned to make verbally to conclude the programme. I did not do so at that time, partly because of the shortage of time, and because of the fact that many of these ideas had already been expressed at various times by the panel members, and by Dr. John Robertson Unwin, of Montreal, in his commentary from the floor at the end of the meeting. After rereading the above record, however, I am impressed that it makes a valuable contribution which might be made more valuable by me giving emphasis here to my own personal judgements on two points:

1. That almost every statement made by each of the four panel members I would heartily support as being valid and useful.

2. The one exception is one point only made by each of two speakers, which I believe gives an erroneous impression, which should be corrected.

Just prior to the opening of this panel, I had expressed to Dr. Shamsie my amazement at the choice of the question: "Do adolescents need separate treatment facilities?" This question seemed quite anachronistic in light of my own clinical experience, and observations during my recent visits to hospital programmes for adolescents through the United States and Europe. In fact, I observed to him, privately in an off-hand comment coloured by only a little poetic license, that today's question would seem almost analogous to a proposal that we discuss whether the horseless carriage will ever prove to be of practical use! Granted, that twenty years from now the automobile may well be replaced by helicopters, and we may one day discover a better substitute for an all-adolescent ward. In the meantime, among those having first-hand knowledge of the actual results of treating adolescents in separate wards (which does not include all members of this panel) the facts seem to speak for themselves.

The state of our knowledge in psychiatry is such that many important questions still provide the basis for serious controversies. Yet even in our terribly imperfect and uncertain discipline, not all questions are controversial. Some of our controversies are bona fide controversies and some are pseudo controversies, which can be maintained as such only by a failure to consider all of the available evidence.

Those speakers, Drs. Sarwer-Foner and Lehmann, who have argued clearly against any proper usefulness for separate hospital facilities, and in favour of dispersing all hospitalized adolescents within adult populations as the solution, have been able to maintain this position only by disregarding part of the relevant data. They have cited disadvantages to the all-adolescent ward–such as the potential for over-specialization on the part of the psychiatrists, and the potential for accentuating behaviour problems in certain patients. They have noted advantages to housing the adolescents within adult ward populations, such as the fact that uncontrolled behaviour may be more readily brought under control there. These arguments are perfectly valid, and would not be questioned by any of us as being critical factors in the planning of treatment for certain adolescent patients. Unfortunately, however, these speakers have made no reference to extensive clinical experience, reports of some of which are available in our psychiatric literature, supporting conclusions quite opposite to those which they have reached: namely, that there are distinct advantages to treating some adolescents in all-adolescent wards, and that there are enormous disadvantages to treating some teenagers within adult wards.

Progressively over the past fifteen years in the United States, and over a somewhat shorter period in Canada and in Europe, psychiatrists have been compelled out of the enormous unmet needs for treatment of teenagers to re-examine our previous experience. As a result, we have learned that earlier attempts to treat adolescents within children's wards, within adult wards, and as outpatients or inpatients in the hands of child or adult psychiatrists not specifically prepared to deal with adolescents, have led to results which have often been unsatisfactory. Therefore, it is out of recognition of this need that some of us have developed a special interest in learning how better to treat these youngsters. It is also out of actual experience that many of us have learned that treating adolescents in adult wards in many cases represents a gross disservice to certain patients. We at the University of Michigan, for example, treated increasingly large numbers of adolescents within our adult wards under circumstances of usually favourable staffing conditions and financial support over a six-year period (1950-1956). This experience with several hundred patients led to our conclusion that something different was needed for some of them. As a result, we opened our all-adolescent ward in 1956. In it over the past eleven years we have had an opportunity to learn of some of the specific advantages and limitations to that kind of setting for the treatment of selected patients. At the same time, from choice, we have continued to house certain other teenagers within our adult wards. Psychiatrists everywhere seem to be collecting clinical experience which represents variations on the same theme. Present programmes in the way of separate wards, separate activity facilities, separate staffing, as well as "non-separate" facilities, have grown up in response to actual needs. Psychiatrists have come to recognize, as have all members of this panel including Drs. Sarwer-Foner and Lehmann in most of their comments, that there is a place for a variety of different approaches to the inpatient and outpatient treatment of adolescents.

Consideration of all of our collective clinical experience seems to lead only to the conclusion that some adolescents do need separate treatment facilities and that some others are ideally better treated within adult wards. No other point of view seems tenable in light of our present state of knowledge.

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